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The front cover photo honors the U.S. Navy's very first lady admiral. RADM Alene B. Duerk (center), Director, Nursing Division, BUMED, was ceremoniously promoted on 1 June 1972. Deft assistance was rendered by The Honorable John W. Warner, Secretary of the Navy (right). The enthusiasm and warm support of Admiral Elmo Zumwalt, Chief of Naval Operations (left) were evident.

Invaluable contributions of Mrs. S.B. Hannan, BUMED Code 2133, and the Illustration and Exhibits and Photography Divisions of the Medical Graphic Arts Dept., Naval Medical School, NNMC, Bethesda, Md., are gratefully acknowledged.



from the Chief

The Assistant Secretary of Defense (Health and Environment) now directs the Civilian Health and Medical Program of the Uniformed Services, popularly known as CHAMPUS. For the present, the U.S. Army will continue to provide administrative and logistic support for this program, with headquarters located at Fitzsimons General Hospital in Denver.

In emphasizing what is possibly the most important supplemental benefit for the careerist today, it is essential that the Navy maintain its identity and consistently demonstrate to naval personnel and their families the Navy's role within the Uniformed Services Health Benefits Program (USHBP). In this way, service identification can be maintained and maximum beneficiary acceptance ensured. Supplemental benefits are of little value unless we can conduct the type of counseling and information program that will keep our Navy families adequately informed.

For this purpose, I established a Health Benefits Counseling Program. Designated Health Benefits Counselors (HBCs) at all our naval hospitals, large dispensaries and dental clinics maintain informational material, provide information and guidance to service members (both active and retired) and their families, and support the staff by providing assistance to eligible beneficiaries in obtaining services from civilian sources and other facilities under various health programs, such as, USHBP-CHAMPUS, Social Security MEDICARE, VA, etc. With the support of the Chief of Naval Operations, the HBC coordinated information and counseling network has been extended on a Navy-wide basis to include large commands, naval districts, and fixed overseas medical facilities.

In order to produce optimum results, it is important that each member of the Medical Department identify, cooperate and consult with the HBCs. Their function and value depend to a large extent upon intelligent utilization by medical personnel and beneficiaries. Each of us concerned with health care delivery has a responsibility to promote the widest possible dissemination of information concerning the Health Benefits Counseling Program.



Flag Officer Selection

Donald Lauren Custis was born on 23 July 1917 in Goshen, Ind. He received his BA degree (Sciences) at Wabash College in Crawfordsville, Ind. in 1939 and earned his MD degree at Northwestern University School of Medicine, Chicago, Ill., in 1943. He served his internship at Presbyterian Hospital in Chicago, Ill.

CAPT Custis served as a medical officer in USS CLINTON (APA-144) in the Pacific Theatre, 1944-1946, and then returned to civilian life to pursue surgical postgraduate training at the Mason Clinic in Seattle, Wash., 1946-1950. He subsequently engaged in the private practice of surgery in Seattle, until his return to a naval career in 1956 as a member of the surgical staff at Naval Hospital Portsmouth, Va.

Major permanent duty assignments include: Chief of Surgery, U.S. Naval Hospital, Guantanamo Bay, Jul 1958-Jul 1960; Assistant Chief of Surgery, Naval Hospital Great Lakes, Ill., Jul 1960-Feb 1963; Chief of Surgery, Naval Hospital, Beaufort, S.C., Feb 1963-Jul 1965; Medical Officer-Chief, Surgical Service, Naval Hospital Philadelphia, Pa., Jul 1965-Sept 1967; Medical Officer-Executive Officer, Naval Hospital Philadelphia, Sept 1967-May 1969; Senior Medical Officer, U.S. Naval Support Activity, Danang, RVN, May 1969-May 1970; and CO Naval Hospital, NNMC, Bethesda, Md., since May 1970.

CAPT Custis is a Diplomate of the American Board of General Surgery, a Fellow of the American College of Surgeons, and a member of the American Medical Association, Association of Military Surgeons of the U.S., and the Philadelphia Academy of Surgery.

In addition to the Legion of Merit with Combat "V," CAPT Custis has the Combat Action Ribbon, China Service Medal, American Campaign Medal,

Asiatic-Pacific Campaign Medal, World War II Victory Medal, Navy Occupation Service Medal with Asia Clasp, National Defense Service Medal with one Bronze Star in lieu of second award, Vietnam Service Medal with one Bronze Star, Republic of Vietnam Campaign Medal with Device (1960-) and the Armed Forces Honor Medal First Class by the Republic of Vietnam.



CAPT Donald L. Custis, MC, USN

Alene Bertha Duerk was born in Defiance, Ohio, on 29 March 1920. She graduated in 1941 from the Toledo (Ohio) Hospital School of Nursing and was appointed Ensign in the Nurse Corps of the U.S. Naval Reserve on 23 Jan 1943. She transferred from the Naval Reserve to the U.S. Navy in December 1953.

After serving as a Ward Nurse at Naval Hospitals Portsmouth, Va., and Bethesda, Md., RADM Duerk joined the USS *BENEVOLENCE* (AH-13) in May 1945. After cessation of hostilities, *BENEVOLENCE* remained in Japanese waters to assist in the processing of liberated Allied prisoners of war, and returned to the U.S. late in 1945. Following duty on the staff at Naval Hospital, Great Lakes, RADM Duerk was released from active naval service in June 1946. In 1948 she received the degree of Bachelor of Science in Ward Management and Teaching, Medical and Surgical Nursing, at Western Reserve University in Cleveland, Ohio. She was subsequently employed as Supervisor and Instructor, Medical Nursing, at Highland Park (Michigan) General Hospital and joined a ready naval reserve unit in Detroit, Mich., in 1948.

Returning to active naval service in June 1951, RADM Duerk held numerous interesting assignments which included the following: Nursing Instructor at Naval Hospital Corps School, Portsmouth, Va.;

Interservice Education Coordinator at Naval Hospital, Philadelphia, Pa.; Nurse Programs Officer at Naval Recruiting Station, Chicago, Ill.; Charge Nurse at U.S. Naval Station Hospital, Subic Bay, R.P.; Assistant Chief Nurse at U.S. Naval Hospital Yokosuka, Japan; Chief of the Nursing Branch at the Naval Hospital Corps School, San Diego, Calif.; Assistant for Nurse Recruitment in the Office of the Deputy Assistant Secretary of Defense (Health and Medical), Washington, D.C.; Assistant Head of Medical Placement Liaison (Nurse Corps), Bureau of Naval Personnel, Navy Dept.; and Chief of Nursing Service, Naval Hospital Great Lakes, Ill.

In May 1970 RADM Duerk became Director of the Navy Nurse Corps, BUMED, Navy Dept. She was promoted to Rear Admiral on 1 June 1972, the first lady in the U.S. Navy to have ever been honored by promotion to flag rank.

RADM Duerk wears the following ribbons: American Campaign — Asiatic Pacific Campaign; World War II Victory; Navy Occupation Service Medal; National Defense Service Medal with Star; and the Naval Reserve Medal.

A member of the American Nurses' Association and the National League of Nursing, RADM Duerk brings to her high office a strong sense of duty, purpose and dignity. She was the first to be frocked among the FY 1973 flag officers.



THE NAVY'S FIRST LADY ADMIRAL —
RADM Alene B. Duerk, NC, USN

Philip Oldham Geib was born in Verona, N.J., on 6 Oct 1921. He received a BS (General Science) degree in 1942 at Franklin and Marshall College, and an MD degree at Temple University School of Medicine in Philadelphia, Pa., in June 1945. During June 1945 he commenced his internship at Naval Hospital Boston, Chelsea, Mass., as a LT(jg) in the Navy Medical Corps. After serving subsequently as Medical Officer at Leyte Samai, P.I., and at Naval Hospital Portsmouth, Va., he began his training in General Surgery in 1948 at the Naval Hospital, Philadelphia. Following surgical assignments at Naval Hospital Corpus Christi, Tex.; Naval Medical Unit Tripler Army Hospital, Hawaii; and in USS *VALLEY FORGE* (CVA-45), he returned as Chief Surgical Resident to Naval Hospital, Portsmouth, Va. Upon completion of his surgical training, CAPT Geib was certified by the American Board of Surgery.

Additional assignments included the following: Assistant Chief of Surgery at Naval Hospital Annapolis; Surgeon and Senior Medical Officer in USS *IOWA* (BB-61); Assistant Chief and Chief of Surgery at Naval Hospital, Portsmouth, Va.; Chief of Surgery at Naval Hospital, Pensacola, Fla., and Naval Hospital Great Lakes, Ill.; Executive Officer and Chief of Surgery at U.S. Naval Hospital, Yokosuka, Japan; CO of U.S.



CAPT Philip O. Geib, MC, USN

Naval Hospital Yokosuka with additional duty as Staff Medical Advisor, U.S. Forces Japan and Force Medical Officer, Naval Forces Japan. He assumed command of Naval Hospital, Camp Lejeune on 4 Aug 1971.

CAPT Geib is a Diplomate of the American Board of Surgery, a Fellow of the American College of Surgeons and the American College of Chest Physicians, and a member of the American Medical Association and the Pan American Surgical Society.

In addition to the Navy Unit Commendation awarded U.S. Naval Hospital Yokosuka, Japan, CAPT Geib has the American Campaign Medal, the World War II Victory Medal, the National Defense Service Medal with one Bronze Star in lieu of second award, the Korean Service Medal and the United Nations Service Medal.

Wade Hampton Hagerman, Jr., was born in Tazewell, Va., on 12 Nov 1921. He attended Marshall College in Huntington, W.Va.; received his DMD degree in 1945 at the University of Louisville School of Dentistry, Louisville, Ky., and was then commissioned a LT(jg) in the Dental Corps of the U.S. Naval Reserve. After serving on active duty at the Naval Training Center, Camp Perry, Va.; in USS STEAMER BAY (CVE-87); and at the Submarine Base, Pearl Harbor, he was released to inactive duty in 1947.

Following three years spent in private practice in Matewan, W.Va., RADM Hagerman returned to active duty in 1950 and served subsequently: at the Naval Administrative Command, San Diego; in USS JUNEAU (CLAA-119); and at the Navy Dept. Dispensary in Washington, D.C. He transferred from the Naval Reserve to the U.S. Navy Dental Corps in 1951. Advanced professional training courses were later completed as follows: General Postgraduate Course, and Advanced Course in Crown and Bridge Prosthodontics, at the Naval Dental School, NNMCMC, Bethesda; and Advanced Course in Crown and Bridge Prosthodontics at the University of Michigan, Ann Arbor, Mich.

Subsequent assignments included the following: Staff Officer at Naval Dental School, NNMCMC, Bethesda; CO 22nd Dental Co., FMF Atlantic, Camp Lejeune, N.C.; and CO Naval Dental Clinic, Camp Pendleton, Calif. On 1 Jul 1972, RADM Hagerman was promoted to his present rank and is expected to relieve CAPT W.C. Wohlfarth, Jr., DC, USN, as CO of the Naval Graduate Dental School, NNMCMC, Bethesda, Md.

RADM Hagerman is a member of the American Dental Association, American Academy of Crown and Bridge Prosthodontics, American College of Dentists, American Academy of Gold Foil Operators, and International Association for Dental Research.



CAPT (now RADM) Wade H. Hagerman, Jr., DC, USN



CAPT William J. Jacoby, Jr., MC, USN

In addition to the Navy Commendation Medal, RADM Hagerman has the American Campaign Medal, World War II Victory Medal, Navy Occupation Service Medal with Europe Clasp, National Defense Service Medal with one Bronze Star in lieu of second award, Korean Service Medal, Korean Presidential Unit Citation Badge and the United Nations Service Medal.

William Jerome Jacoby, Jr., was born at Mount Carmel, Pa., on 9 Aug 1925. He joined the U.S. Navy V-12 Unit at Emory University, Ga., where he received his BA degree and was appointed ENS in June 1946. He earned his MD degree at Jefferson Medical College in 1950, and obtained much of his postgraduate training in internal medicine at Jefferson Medical College Hospital in Philadelphia, Pa.

Following graduation from the U.S. Navy School of Aviation Medicine in April 1953, he served as flight surgeon in USS PALAU (CVE-122) and KULU GULF (CVE-108). From Aug 1957 to Jul 1958, CAPT Jacoby was a resident in cardiovascular disease at Naval Hospital Bethesda, Md. Subsequent duty assignments and titles include: Chief, Cardiopulmonary Laboratory, Naval Hospital Portsmouth, Va., 1959-1964; Chief, Medical Service, Naval Hospital Great Lakes, Ill., 1964-1969; Chief, Internal Medicine Service and Chief, Clinical Investigation Service, Naval Hospital Philadelphia, Pa.,

1969-1972. During the latter assignment he was also appointed Clinical Associate Professor of Medicine at Thomas Jefferson University Medical School.

CAPT Jacoby was elected to Alpha Omega Alpha in 1949 and served as Phi Beta Pi President 1949-1950. He is certified by the American Board of Internal Medicine, a Fellow of the American College of Physicians, and a member of the International Society of Internal Medicine, the American Medical Association and the Association of Military Surgeons of the U.S.

Rear Admiral Selectee Jacoby has the American Campaign Medal, the World War II Victory Medal, Navy Occupation Service Medal with Europe Clasp, and the National Defense Service Medal with one Bronze Star in lieu of second award.

Edward Jerome Rupnik was born on 8 May 1924 in Library, Pa. He completed recruit training in Oct 1943 at Great Lakes, Ill., and served as a Hospital Corpsman at Naval Hospitals Great Lakes and Philadelphia, in 1943-1944. He joined the V-12 Unit at the University of Pittsburgh, Pa., where he earned his BS degree in 1944. After receiving his MD degree at the University of Pittsburgh School of Medicine in 1948, CAPT Rupnik underwent four years of postgraduate surgical training at Naval Hospital, Bethesda, Md., and spent an



CAPT Edward J. Rupnik, MC, USN



CAPT George D. Selfridge, DC, USN

additional academic year in Surgery at the University of Pennsylvania Graduate School of Medicine in 1953-1954.

Duty assignments have included the following: Medical Officer (LST DIV. 34), Amphibious Force Pacific, Korea, Jul 1950-Oct 1951; Surgical Staff at Naval Hospital Bethesda, June 1954-June 1956; Senior Surgeon, Station Hospital, Joint Military Aid Group to Greece, Athens, June 1956-June 1958; Chief, Dependent Surgery, Naval Hospital, Bethesda, Jul 1959-Oct 1962; Chief of Surgery, Naval Hospital Quantico, Va., Nov 1962-Aug 1965; Chief of Surgical Service, Naval Hospital Portsmouth, Va., Aug 1965-Jul 1969; Head, Training Branch of Professional Division, BUMED, Jul 1969-Mar 1971; and CO Naval Medical School, NNMC, Bethesda.

CAPT Rupnik is a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons. His academic appointments include: Assistant Clinical Professor of Surgery, 1962-1965; and Clinical Professor of Surgery, 1970-1972, at Georgetown University. He received the AMA Physicians Recognition Award in 1969.

In addition to the Navy Commendation Medal with one Gold Star in lieu of second award, and the Navy Unit Commendation awarded USS HENRICO (APA-45), CAPT Rupnik holds the American Campaign Medal, the World War II Victory Medal, the National

Defense Service Medal with one Bronze Star in lieu of second award, the Korean Service Medal, the Korean Presidential Unit Citation Badge, and the United Nations Service Medal.

George Dever Selfridge was born on 24 Sept 1924 in Pitman, N.J. Following graduation from Pitman High School in 1942, he attended Gettysburg College in Gettysburg, Pa., during 1942-1943. In the fall of 1942 he commenced his naval association and was assigned to active duty in the V-12 Education Program. In 1945 he served as an apprentice dental technician at the Naval Training Center, Bainbridge, Md.

CAPT Selfridge earned his DDS degree in 1947 at the State University of New York in Buffalo. He commenced active naval service as a dental officer in 1948 and subsequently served in that capacity in ships and at numerous stations and Marine Corps Units. Major permanent duty assignments included: Assistant Dental Officer, Dental Dept., NAS Norfolk, Va., June 1960-May 1963; Senior Dental Officer, USS CADMUS (AR-14) and additional duty as Force Dental Officer, Staff, Commander Service Force, U.S. Atlantic Fleet, May 1963-Oct 1964; Dental Officer, USS VULCAN (AR-5) and additional duty as Force Dental Officer, Staff, Commander Service Force, U.S. Atlantic Fleet, Oct 1964-Aug 1965; Dental Officer, Fleet Anti-Air Warfare Training Center, Dam Neck, Virginia Beach, Aug 1965-June 1967; Force Dental Officer, Staff, Commander Submarine Force, U.S. Atlantic Fleet, June 1967-Jul 1969; and Head, Publications Dept./Head, Educational Resources Dept., Naval Graduate Dental School, NNMC, Bethesda, Jul 1969-Mar 1972. At the time of his selection to flag rank, CAPT Selfridge was a member of the staff at the Naval Dental Clinic in Norfolk, Va., where he is presently assigned as Executive Officer. Enrolled in a Master Program for Higher Education at George Washington University, he is working towards a master's degree.

CAPT Selfridge's experience, knowledge, and dental service to fleet activities have earned him an official letter of commendation from the Commander Submarine Force, Atlantic. While serving as Assistant Director of the Education Program at the Naval Graduate Dental School, NNMC, Bethesda, CAPT Selfridge helped design and develop two Master Degree Programs in cooperation with George Washington University for graduate residents and staff. For this contribution he received a letter of commendation from the Commanding Officer of the Naval Graduate Dental School. CAPT Selfridge is a member of the American Dental Association, The Academy of General Dentistry, and the American College of Dentists.

In addition to the American Campaign Medal, CAPT Selfridge has the World War II Victory Medal, the Navy Occupation Service Medal with Europe Clasp, the National Defense Service Medal with one Bronze Star in lieu of subsequent award, and the Armed Forces Expeditionary Medal (Lebanon). 🇺🇸

A Transient Situational Addiction to Heroin

By LT Gary W. Nyman, MC, USNR,
2nd Hospital Company, Force Troops,
Fleet Marine Force, Atlantic,
Camp Lejeune, North Carolina.

ADMINISTRATIVE BACKGROUND

In July 1971, President Nixon issued an Executive Order, conveyed to United States Marine Corps (USMC) personnel in the form of Almar/77,¹ which created a drug exemption and treatment program. In summary, the message enabled all USMC drug abusers to turn themselves in to their commands for treatment of their drug problems, without incurring punitive action. The program did not exempt those persons already apprehended for possession or abuse of illegal drugs. This report describes an apparent pattern of self-limited addiction to heroin observed among participants in the Force Troops, Fleet Marine Force Atlantic (FMFLANT) Drug Exemption Program during the first three and one-half months of the program's existence.

From 1 Aug 1971 through 15 Nov 1971, each participant in the Force Troops Drug Exemption Program

was psychiatrically evaluated by the author for purposes of diagnosis and appropriate disposition. In addition to evaluation for underlying psychosis, crippling neurosis and/or organicity, emphasis was placed on determining the exemptee's motivation for treatment in relation to desire for rapid discharge from the service. During each evaluation the nonpunitive nature of the exemption program was clearly reemphasized. Each man was advised that there was no benefit to be gained from misrepresenting his history or exaggerating his drug abuse. Treatment-rehabilitation and/or discharge were recommended for each man, based more on how he perceived his current drug problem than on the history of drugs abused.² To the author's knowledge, there has been no legal action taken, to date, against any exemptee as a result of self-disclosure.

GENERAL PATTERNS

Force Troops, FMFLANT, consist of approximately 6000 United States Marines. During the first three and

The author is presently serving on active duty with Force Troops, Fleet Marine Force Atlantic.

The opinions expressed herein are those of the author and cannot be construed as reflecting the views of the Navy Department or of the naval service at large.

1. Almar/77-CMC MSG 192338Z Jul 71 (MCBUL 6710 of 19 Jul 71) (Administrative Procedures established by Almar/90-CMC MSG 181752Z Aug 71 (MCBUL 6710 of 18 Aug 71).

2. One exception to this procedure was a man currently addicted to heroin who was handled in a different manner. An exemptee with a history of daily heroin abuse up to the time of his volunteering for the program, was first admitted to an inpatient facility for observation and acute detoxification if necessary. He was then returned for further evaluation.

one-half months of the newly-established program, 161 Marines volunteered for the Drug Exemption Program. All were between the ages of 17 and 21 years, serving their first tour of active duty, and ranging in rank from private to sergeant (E-5). Of these 161 men, 55 gave a history of abusing other drugs in addition to heroin, taking it on at least ten separate occasions during their last twelve months of active duty.

The 55 men can be grouped arbitrarily into two categories. One category contains 29 men who might be classified in the following manner: Some abused heroin before they entered the USMC; others abused heroin either before, or after, they were stationed overseas; and still others abused heroin less frequently than six days a week while stationed overseas.

The other category contains 26 men. Each man gave a history of trying, or abusing, drugs other than heroin³ before his deployment to the Far East. All 26 men began to abuse heroin shortly after their arrival in Vietnam or Okinawa. Each of these men related that he had eventually abused heroin at least twice a day, for a period of two to twelve months, while stationed in Vietnam or Okinawa. Only five of the men admitted to employing the intravenous route of drug administration. The remaining 21 men utilized the intranasal route. All 26 men had made some attempt to discontinue heroin abuse within the last two months of their overseas tour. All 26 related that they had experienced withdrawal symptoms and signs, including anorexia, nausea, myalgia, stomach cramps, rhinorrhea, and vomiting, which lasted from three to ten days. In spite of self-admitted failures and repeated withdrawal trials, only two of the 26 men admitted to continued occasional heroin abuse within one month following return to continental United States. However, all of the 26 men admitted to continued abuse of other non-opiate drugs. All knew that heroin in the U.S. was weaker, far more expensive, and readily available to them upon their return. Six of the 26 men considered that they might try heroin occasionally in the future. None saw it as part of their present or future life style. To date, the reported interval of total abstinence from heroin within the group ranges from two to eleven months.

CASE REPORT

WN, a 19-year-old White E-3, readily admitted to joining the Drug Exemption Program in order to obtain

3. Included among these drugs are: marijuana, hashish, mescaline, psilocybin, LSD or lysergic acid, barbiturates, amphetamines, THC (tetrahydrocannabinol) and DMT (dimethyltryptamine).

a rapid discharge from the USMC. He had been in the USMC for just under two years. He told of first abusing drugs by smoking marijuana shortly after completing his basic training. He was subsequently transferred to Vietnam for an eleven-month tour of duty.

In Vietnam, he found heroin readily available and inexpensive. The "high" he experienced with it was much more pleasant and relaxing than the "high" provided by readily-available liquid amphetamine (moo juice). The rapid effect and ease of snorting heroin eliminated the problem presented by marijuana — the readily-detected smell. The pace of work was slow, others were on drugs, and no one really seemed to mind very much. WN recalls that, within a few weeks, he was snorting heroin two to four times each day.

He continued to abuse heroin daily for a period of seven to eight months. When about two months remained before his return to the U.S., he decided to try to stop taking heroin. Significant factors which motivated him to stop were: the fear of detection by tests, progressive weight loss ("... my body was torn down, man ..."), and the cost of maintaining his habit in the U.S.

WN visited a corpsman and got some "brown pills" to help ease the pain which he had been told to expect. He commenced taking the pills three times a day and abruptly stopped taking heroin. He was unsuccessful on this first attempt. On the second try one week later, he was able to tolerate the nausea, severe stomach cramps, and malaise that persisted intensely for six to seven days. WN estimated that he had lost 35 pounds in weight during eleven months spent overseas; some of this weight loss occurred during the ten miserable days of withdrawal.

Since his return to the U.S., WN admits to continued abuse of marijuana, acid, and mescaline which he regards as part of his social life style. He claims that he does not feel the need to abuse heroin, or any drug, on a daily basis. He states that he has remained off of heroin for almost five months, to date.

DISCUSSION

The preceding observations leave many questions unanswered. Foremost among them is the question of validity of case histories without medical documentation. Due to the structure of the Drug Exemption Program, it has not been possible to establish a control group and obtain follow-up information from these Marines. Such observations and their relation to any general trends can be no more than implied from the information gathered.

However, the lack of secondary gain to be derived from case history misrepresentation would favor the

validity of emerging impressions of a rather consistent heroin abuse pattern, as gleaned from exemptees' histories. This pattern indicates that former nonheroin drug abusers began abusing heroin daily, shortly after their arrival in Okinawa or Vietnam. The heroin available to them was relatively uncut, inexpensive and accessible. Their heroin abuse had the apparent features of addiction, with increased tolerance and withdrawal symptomatology. Despite their accounts of repeated withdrawal attempts, the overwhelming majority of exemptees were ultimately successful in eliminating heroin abuse.

The physiologic alterations of addiction may have had greater significance than any common underlying psychopathology among these enlisted men with a particular pattern of heroin addiction. Drug abuse was familiar to these men. Further abuse was possibly provoked by transfer to an unfamiliar Far East combat area. The heroin "high" may have reconciled these men to an alien overseas environment, initially making it pleasantly tolerable. Despite any increasing tolerance, the "high" may have continued to provide escape from harsh daily realities. As the end of the Far East tour approached, the impending transfer home may have diminished the need for continued perceptual alteration. The overseas addict may then have been able to justify and accept the discontinuation of his addiction. Withdrawal may then have posed more of a problem in physical terms — tolerating complete physiologic withdrawal — than in terms of overcoming psychological dependence.

The scope of heroin addiction in military men overseas has recently been of great national concern, particularly in view of the poor rehabilitation results observed in traditional treatment facilities.⁴ Under the

4. Duvall HJ, Locke BZ and Brill L: Follow-up study of narcotic drug addicts five years after hospitalization. Public Health Report 78:185-198, 1963.

President's direction, focus has been placed on the rapid establishment of treatment and rehabilitation programs for drug addicts within the military and Veterans Administration systems. Underlying this approach may be the basic assumption that a heroin addict faces an inevitable cycle of addiction, crime, arrest, institutionalization and readdiction.

Grouping these heroin addicts returned from the Vietnam conflict with traditional heroin addicts does not seem justified at present. Dr. Richard S. Wilbur, Assistant Secretary of Defense (Health and Environment), has noted that chances for rehabilitation are much better for the heroin addicts among enlisted men.⁵ Such optimism toward successful rehabilitation of these addicts may not be due to any innovation in treatment approaches, but rather to the circumstances surrounding the addiction itself. With escape from the particular setting in which the addiction occurred, the heroin "high" may lose its importance in the enlisted man's life style. Continued abstinence from heroin use may be more firmly entrenched as he resumes familiar living patterns upon return home.

SUMMARY

Of the first 161 men evaluated in the Drug Exemption Program in Force Troops, FMFLANT, a self-limiting experience with heroin addiction was reported by 24 men. Their addiction began and terminated while stationed with the U.S. Marine Corps in Vietnam or Okinawa. The customary implications of becoming a narcotic addict in the traditional sense, remaining caught in a cycle of addiction, institutionalization, and readdiction, may not be applicable to the situation described.

5. End to Vietnam drug abuse foreseen, Hospital Tribune, 1 Nov 1971, pp 1, 16.

(Continued from p. 46)

For courses at the Naval Dental Center, San Diego, Calif., career dental officers and Reserve dental officers on active duty should submit their applications via the chain of command and in accordance with current directives to the Commandant, Eleventh Naval District (Code 37), San Diego, Calif. 92132, using the format contained in MANMED article 6-130. Active status Naval Reserve dental officers on inactive duty will

apply to the Commandant of the district in which they reside.

Applications should be submitted so as to be received at least one month prior to the convening date of the course. Officers will be notified regarding the action taken on their requests. Those approved will be nominated for TAD, authorization orders, or active duty for training, as appropriate.



A RATIONAL APPROACH to the MANAGEMENT of ANGINA PECTORIS

By LCDR Carl J. Pepine, MC, USN and CDR Carl R. Bemiller, MC, USN,*
Research Division and Cardiopulmonary Laboratory, Medical Service,
Naval Hospital, Philadelphia, Pa.

Therapeutic measures available for relief of angina pectoris act by diminishing myocardial oxygen consumption (MVO_2) and/or improving myocardial oxygen flow. Traditionally, attention has focused on the latter of these mechanisms as attempts were made to increase coronary blood flow (CBF). Since the ability of a diseased coronary circulation to dilate is limited in patients with advanced coronary artery disease, this approach was modified. Angina pectoris treatment then evolved almost completely from interventions which altered MVO_2 rather than CBF. With the current availability of more specific pharmacologic agents and direct coronary bypass surgery, a more rational view must now be constructed. In this discussion a newer concept will be advanced — that clinical benefits

derived from mechanical, pharmacologic and surgical techniques used in the treatment of angina pectoris result from alterations of MVO_2 and CBF, in relation to a given level of activity.

Mechanical Measures

Several mechanical approaches to relief of angina pectoris are available. Although these measures are immediately effective, they are often overlooked by practicing physicians. Carotid sinus stimulation, Valsalva's maneuver, and phlebotomy are three of the major mechanical methods available for treatment of angina. *Carotid sinus massage*,¹ popularized by Levine because of its almost specific effect on anginal symptoms,² has also been proposed as a clinical test for angina pectoris.³ Recently, Braunwald and associates popularized the use of electrical carotid sinus stimulation by surgically implanted electrodes.⁴ Carotid sinus stimulation in animals increases afferent impulses to central autonomic centers, resulting in reflex inhibition of sympathetic stimulation to the heart and peripheral circulation, with reflex bradycardia

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from vagal stimulation.⁵ These reductions in systemic arterial pressure and heart rate are accompanied by reduced myocardial contractility, all tending to diminish myocardial oxygen demand. Recently presented evidence indicates that carotid sinus stimulation may also increase CBF. This technique is useful in relieving the acute anginal episode or in prophylaxis.

The *Valsalva maneuver* was proposed several years ago as a therapeutic measure in angina pectoris.⁶ Its mechanism of action has been evaluated in our laboratory and appears to be much more complex than originally thought.⁷ Briefly, sudden increase in intrathoracic pressure during the strain phase of the Valsalva maneuver effects abrupt reductions in left ventricular developed pressure, rate of rise of pressure, duration of systole, left ventricular size, and cardiac output. The Valsalva maneuver's effect on all determinants of myocardial tension is most striking. These sudden changes in myocardial oxygen requirement immediately benefit ischemic myocardium and result in abrupt reduction of left ventricular end-diastolic pressure associated with relief of angina pectoris. Additional advantages of both carotid sinus massage and the Valsalva maneuver are that they are both immediately effective and can be performed repeatedly.

Phlebotomy, by reducing venous return and consequently ventricular size, reduces myocardial tension.⁸ This technique, while also immediately effective, is generally reserved for patients who are polycythemic, volume overloaded, or who present signs of acute pulmonary edema. This measure can also be used cautiously

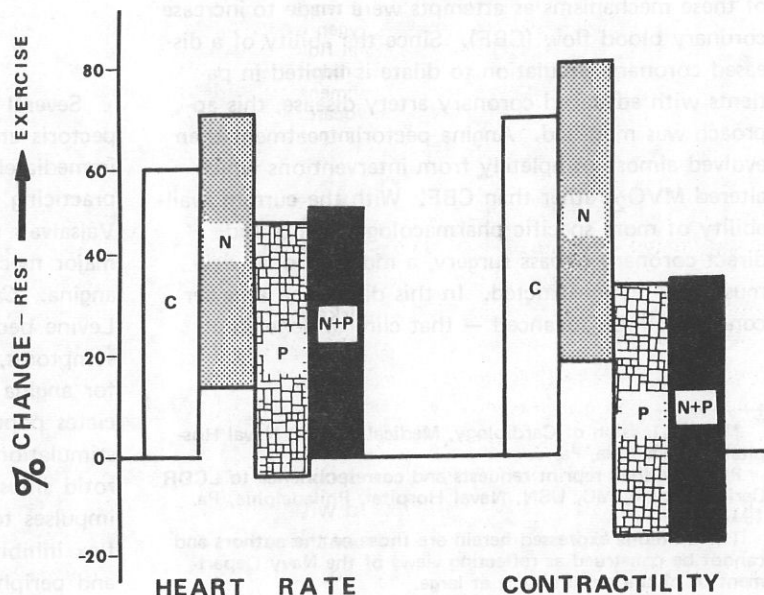
in the hospitalized patient with repeated anginal episodes or so-called *status anginosus*.

Pharmacologic Management

Nitrates. The cornerstone of pharmacologic management of angina is nitroglycerin. Its action includes the following: reduction of left ventricular systolic pressure,⁹ ejection time and size.¹⁰ These changes occur as a result of arteriolar and venular dilatation which reduces venous return and thereby decreases MVO_2 . Nitroglycerin, however, causes some circulatory changes which tend to increase MVO_2 . They include reflex increases in heart rate and the inotropic state.¹¹ (Figure 1) It is also likely that nitroglycerin has a more direct influence, selectively dilating collateral channels to ischemic myocardium which are not under the dilator influence of local products of ischemic metabolism.¹² (Figure 2) The beneficial effect of sublingual nitroglycerin is probably most related to venodilatation, resulting in peripheral pooling of blood with reduction of left ventricular dimensions, systolic wall tension, and diminished MVO_2 . (Figure 2)

Several other nitrate compounds are useful in the management of ischemic heart disease. Since the cardiocirculatory effects of relatively slowly-absorbed sublingual nitroglycerin differ from fast-acting nitrates, such as inhaled amyl nitrite and intravenous nitroglycerin, their effects are worth reviewing. Both intravenous nitroglycerin and amyl nitrite produce sudden, large decreases in systemic arterial pressure in contrast

Figure 1.—Heart rate and contractility actions of nitroglycerin (N) and propranolol (P) and their combination (N+P) are illustrated in patients with angina pectoris from rest to exercise. C = control state (no drug). Comparison demonstrates that while heart rate and contractility tend to increase at rest and with exercise, propranolol reduces these two parameters. The ability of the combination of these agents to attenuate such effects partially explains the synergism attributed to nitroglycerin and propranolol in combination.



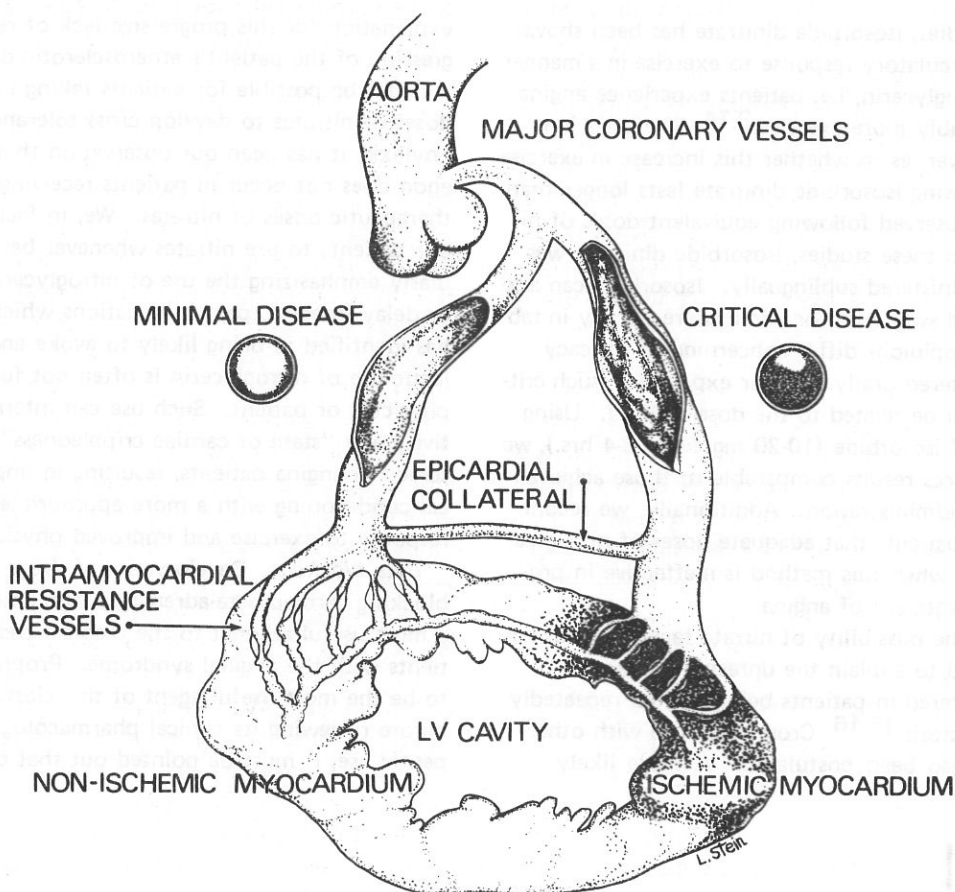


Figure 2.—Analysis of coronary flow dynamics is helpful in understanding drug effects on myocardial perfusion. Ischemic myocardium supplied by a coronary artery with critical narrowing (right), and nonischemic myocardium supplied by vessels with minimal disease (left), are illustrated. With significant proximal coronary arterial narrowing, epicardial collaterals attempt to sustain flow to the low pressure area distal to the obstruction. Additionally, intramyocardial collateral channels augment flow to ischemic regions under the dilator influence of anaerobic by-products. While intramyocardial vessels are generally spared in atherosclerotic disease, their resistance is also dependent upon myocardial wall tension. Anti-ischemic therapy could be directed to: (1) reduction of left ventricular cellular oxygen demands, (2) increasing intramyocardial collateral flow, or (3) increasing epicardial collateral flow. Nitroglycerin appears to exert its effect by all three mechanisms whereas propranolol acts predominantly through (1). Some other agents are considered "malignant" vasodilators, since they augment coronary blood flow while increasing myocardial oxygen requirements. An increase in myocardial oxygen demand in ischemic areas could be deleterious, particularly when arteriolar tone in nonischemic areas also declines. These conditions favor reduced collateral flow ("steal").

to sublingual nitroglycerin.¹³ Occurring within seconds, profound arteriolar dilatation effects carotid baroreceptor stimulation, producing a marked reflex chronotropic effect and some attenuation of the intense direct arteriolar dilatation. Additionally, with amyl nitrite, hyperventilation and anxiety accompanying its inhalation may contribute to reflex venoconstriction. As a result of the marked decline in resistance to ventricular emptying, coupled with prominent reflex venoconstriction and enhancement of cardiac contractility, cardiac output is increased. These observations indicate that the principal direct action of

inhaled amyl nitrite and intravenous nitroglycerin is on the arteriolar bed, whereas that of sublingual nitroglycerin is on the capacitance veins.¹³ Both of the former agents are useful, at times, in patients with manifestations of myocardial ischemia who are unable to take sublingual nitroglycerin. In our experience this has occurred in managing patients with extensive facial and oral trauma, and those who are unconscious or intubated.

Use of so-called longer-acting nitrites provokes controversy which centers around the time, course, and duration of physiologic action. In a number of well-

controlled studies, isosorbide dinitrate has been shown to alter the circulatory response to exercise in a manner similar to nitroglycerin, i.e. patients experience angina after considerably more exercise.^{9,14} The question persists, however, as to whether this increase in exercise capacity following isosorbide dinitrate lasts longer than the increase observed following equivalent doses of nitroglycerin. In these studies, isosorbide dinitrate was generally administered sublingually. Isosorbide can also be chewed and swallowed or administered orally in tablet form, but opinions differ concerning its efficacy when administered orally. In our experience, such criticism may well be related to the dose utilized. Using larger doses of isosorbide (10-20 mg every 3-4 hrs.), we believe, produces results comparable to those achieved in sublingual administration. Additionally, we recommend to our patients that adequate doses of nitroglycerin be taken, when this method is ineffective in prophylaxis or treatment of angina.

Recently, the possibility of nitrate tachyphylaxis has been suggested to explain the unresponsiveness to nitrates encountered in patients being treated repeatedly for angina pectoris.^{15,16} Cross tolerance with other nitrates has also been postulated. A more likely

explanation for this progressive lack of response is progression of the patient's atherosclerotic disease. While it might be possible for patients taking extremely large doses of nitrates to develop cross tolerance and tachyphylaxis, it has been our observation that this phenomenon does not occur in patients receiving the usual therapeutic doses of nitrates. We, in fact, encourage our patients to use nitrates whenever beneficial, particularly emphasizing the use of nitroglycerin to prevent or delay ischemic pain in situations which the patient has identified as being likely to evoke angina. Prophylactic use of nitroglycerin is often not fully utilized by physician or patient. Such use can interrupt the inactivity and "state of cardiac crippledness" often observed in angina patients, resulting in improved physical conditioning with a more appropriate circulatory response to exercise and improved physical capacity.

Beta blockers. Development of drugs capable of blocking cardiac beta-adrenergic stimulatory effects is a most useful adjunct to the medical treatment of patients with the anginal syndrome. Propranolol appears to be the most useful agent of this class. However, before reviewing its clinical pharmacology and therapeutic use, it must be pointed out that despite

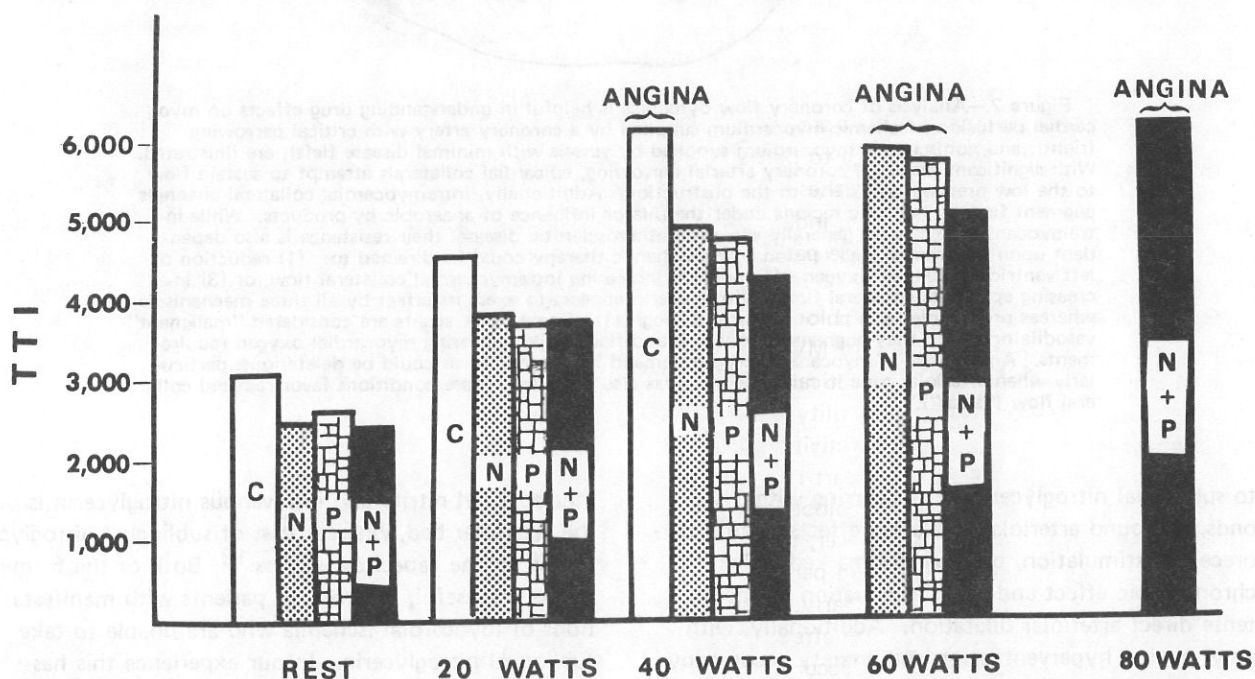


Figure 3.—Combination of nitroglycerin and propranolol. The tension time index (TTI), an index of myocardial oxygen consumption at which angina occurs in the control state (C), with nitrates (N) or propranolol (P), or the combination of these two agents (N+P), is on the vertical axis. During exercise at 40 watts (bicycle ergometer), the patient experienced angina pectoris at a TTI of approximately 4800 mm Hg-sec./min. By their ability to decrease myocardial oxygen consumption, N, P and N+P permitted exercise at this external work load at a lower TTI, aborting angina. When the work load is increased to 60 watts, the critical level of myocardial oxygen consumption associated with angina is reached with N or P alone. However, with N+P, the patient is allowed to perform this work load without attaining the critical TTI. Finally, at 80 watts, the critical TTI is reached as angina occurs.

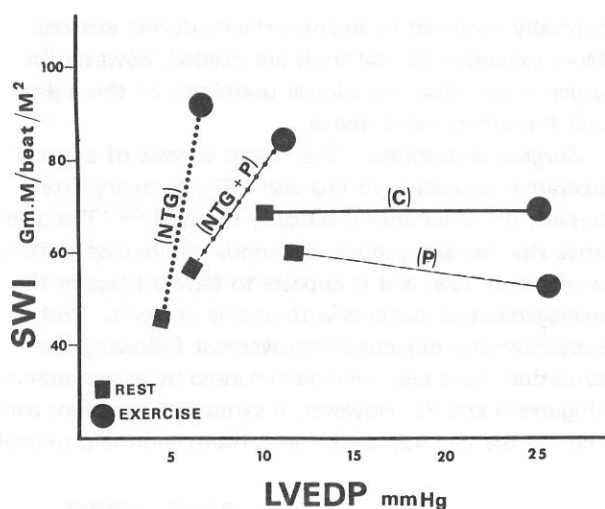


Figure 4.—Figure 4 illustrates the changes in left ventricular function occurring in patients with chronic angina pectoris: in a control state (C), after intravenous propranolol (P), after sublingual nitroglycerin (NTG), and after the combination of nitroglycerin plus propranolol (NTG + P). (LVEDP = left ventricular end-diastolic pressure. SWI = stroke work index.) While propranolol may allay angina, the left ventricular function curve is shifted to the right and downward, indicating depressed left ventricular function. Nitroglycerin shifts the left ventricular function curve upward and to the left, whereas the combination of these two agents provides an intermediate response, indicating improved left ventricular function while myocardial oxygen requirements, as indicated in Figure 3, remain depressed.

propranolol's effectiveness in angina pectoris, it has not yet been approved by the Federal Drug Administration for this use.

Numerous clinical evaluations have shown that in adequate doses propranolol clearly reduces the frequency of anginal episodes and consumption of nitroglycerin in approximately 80% of patients studied.^{17,18,19} These findings have been confirmed in our laboratory utilizing intravenous propranolol which consistently delayed the onset or prevented occurrence of angina during exercise.²⁰ (Figure 3) Additionally, we have followed nearly 100 patients treated with oral propranolol for almost five years and have continued to document its beneficial effects.²¹ The data from these studies and others,²² although not yet complete, indicate that this agent may also prolong the life of the patient with angina pectoris.²¹

Beneficial effects of beta-receptor blockade are primarily achieved through reduction of MVO_2 . Beta blockade directly decreases sympathetically-mediated augmentation of myocardial contractility and heart rate, which necessarily accompany activity. (Figure 2) By reductions in exercise-induced heart rate, contractility, and to some extent, systemic blood pressure, propranolol lowers MVO_2 .^{23,24} However, this drug also tends to prolong the systolic ejection period²⁵ and increase ventricular volume,²⁶ particularly during exercise. These factors have an opposite effect on MVO_2 . Benefit from propranolol probably occurs because its reduction of MVO_2 outweighs the additional oxygen requirement imposed by increases in left ventricular size and ejection time. Additionally, other investigators have suggested that propranolol may induce coronary vasoconstriction in the animal heart.^{27,28} Such a change could occur in response to the reduction in

MVO_2 imposed by propranolol, or by unmasking the alpha-adrenergic-mediated constrictor effect. There is also evidence to indicate that myocardial beta receptors differ from those of the coronary arteries. It is possible that propranolol's effect at these two hypothetically different receptor sites is quantitatively different. That is, propranolol may have minimal influence on the site within the coronary vasculature, tending to reduce CBF, whereas its potent ability to block the myocardial beta-receptor site disproportionately depresses MVO_2 . Recently, however, it has been shown that if heart rate is maintained by pacing, the reduction in CBF and increase in coronary vascular resistance occurring after propranolol are associated with an increase in coronary sinus oxygen concentration.²⁷ This finding would indicate that the overall effect of propranolol is to improve ventricular perfusion relative to oxygen demand.

It is of clinical interest that propranolol and nitroglycerin exert certain opposite effects on MVO_2 .²⁹ (Figure 1) Nitrates induce reflex increases in cardiac contractility and heart rate. Propranolol blocks sympathetically-mediated increases in heart rate and contractility, thus exerting favorable reduction of these oxygen-wasting parameters by a direct effect. Additionally, nitrates tend to decrease left ventricular ejection time and volume, whereas, propranolol increases these determinants of MVO_2 . While synergism in the pharmacologic sense is difficult to document in a clinical setting, the overall result of combined administration of nitrates and propranolol results in a very beneficial effect, delaying angina and further improving exercise capacity. Objective enhancement of these beneficial actions is observed in the reduction of pressure-rate product for any given level of exertion (Figure 3) and improved ventricular function.²⁹ (Figure 4)

As we have implied, it is important in practice to adjust the dosage of these agents for each patient's requirements, using a high degree of symptomatic improvement as an end point. We attempt to make the patient angina-free with usual daily activities. This implies that some patients receive relatively low doses (40 mg daily) while others receive what seem to be massive amounts (>1 Gm daily). This dosage level is achieved over a period of several weeks to months, while close contact is maintained between the patient and the cardiologist. To attain the desired therapeutic response in our patients, the usual dosage averages 240 mg daily. Caution is warranted in those patients who present clinical evidence of myocardial dysfunction, A-V block, hypertension, hypoglycemia, or asthma. Some individuals with cardiac decompensation show improvement when propranolol is combined with digitalis, since sympathetically-mediated contractility effects are known to be independent of digitalis inotropism.³⁰ Nevertheless, because of the possibility of precipitating cardiac decompensation and the wide dosage variation necessary to maintain a reasonable therapeutic end point, propranolol remains an investigational drug. Therefore, its use can only be recommended in the setting of an appropriate, approved protocol.

A variety of newer beta receptor blocking agents has been introduced for clinical evaluation in patients with angina. Many are purported to be relatively cardio-selective, that is, not exerting significant blockade of peripheral (tracheobronchial and arterial) beta receptors. Practolol, one of these agents, has undergone extensive testing in our laboratory.³¹ While this agent has some negative inotropic properties, its anti-anginal effects, in our hands, appear to be considerably less than those derived from propranolol therapy. Practolol, however, may be useful in the treatment of individuals with angina who also have bronchial asthma. The clinical importance of the other beta receptor blocking drugs has not been fully elucidated. Comparison studies in our laboratory suggest that, of all such agents currently available, propranolol offers the most beneficial anti-anginal effect.³¹

A number of newer, non-beta blocker, anti-anginal agents are also undergoing clinical testing. Some that appear more promising include perhexiline, verapamil, lidoflazine, hexobendine, and selenium-tocopherol. In clinical and hemodynamic studies, we have been working with perhexiline,³² an agent which appears to prevent angina by increasing CBF. (Figure 5) This agent is particularly desirable in that its effects are extremely long-acting (several days). Additionally, because of its ability to relieve myocardial ischemia, perhexiline appears to attenuate the left ventricular dysfunction

typically observed in angina patients during exercise. More extensive clinical trials are needed, however, in order to establish the clinical usefulness of this agent and the others listed above.

Surgical procedures. The recent success of a direct operative procedure to increase CBF, coronary artery bypass, has been enthusiastically received.³³ The operative risk for autogenous saphenous vein bypass grafting is relatively low, and it appears to have a place in the management of patients with angina pectoris. Both subjective and objective improvement following the procedure have been well-documented by us and others. (Figures 6 and 7) However, a variety of questions concerning the patency of the graft itself, and the proximal

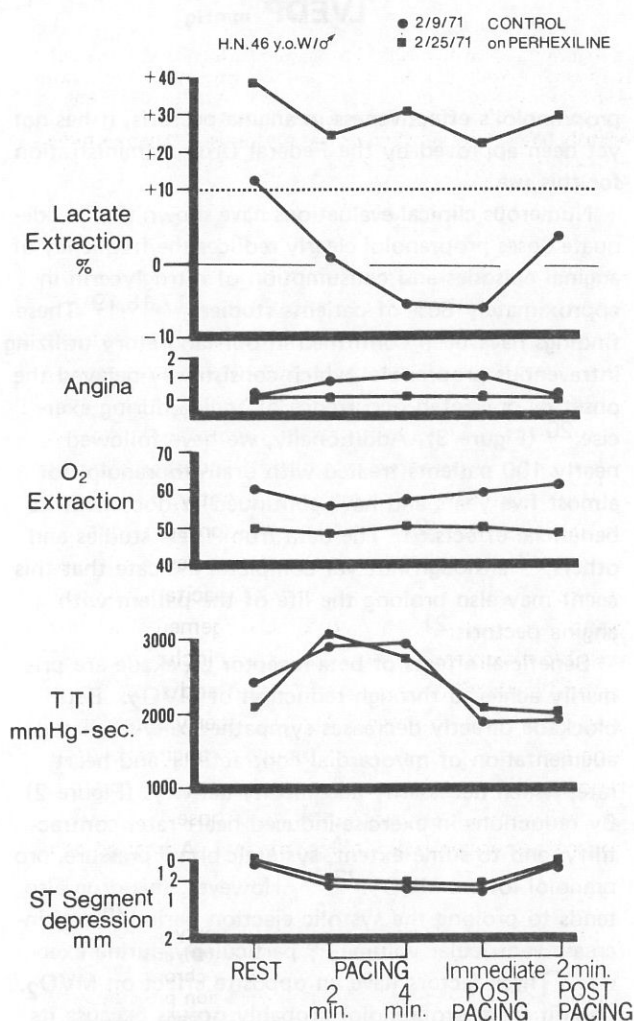


Figure 5.—Figure 5 illustrates the beneficial effects derived from the coronary vasodilator, perhexiline. Prior to treatment (●): the patient's myocardial lactate extraction is reduced during pacing, lactate production occurs in association with angina pectoris, myocardial oxygen requirements indicated by the tension time index (TTI) increase. While on perhexiline (■), lactate extraction remains essentially normal, as angina does not occur at the same level of myocardial oxygen requirement.

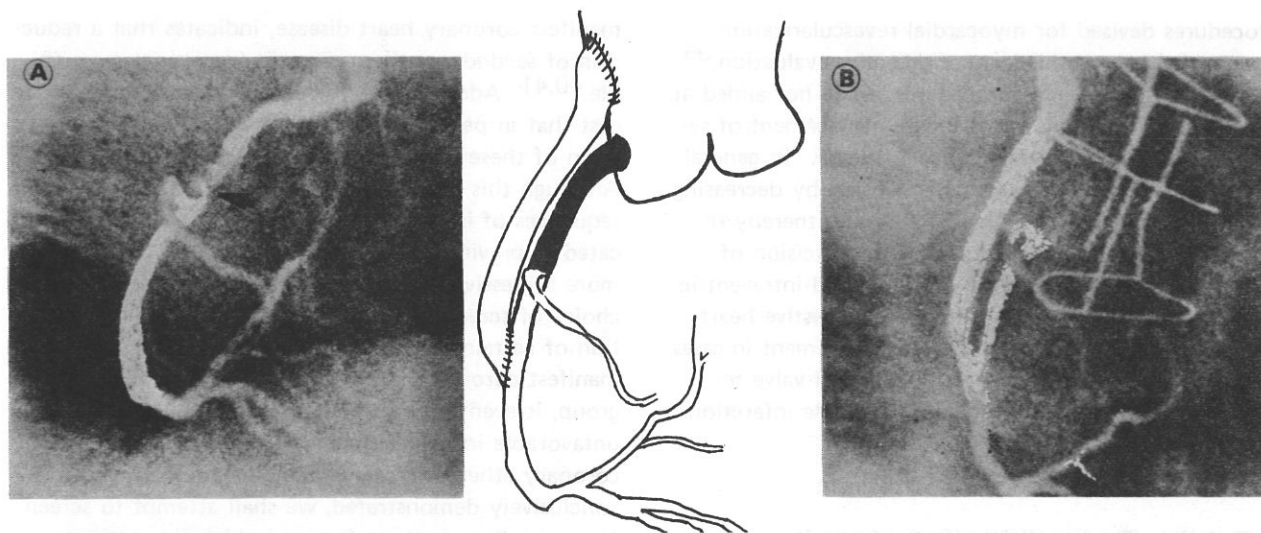
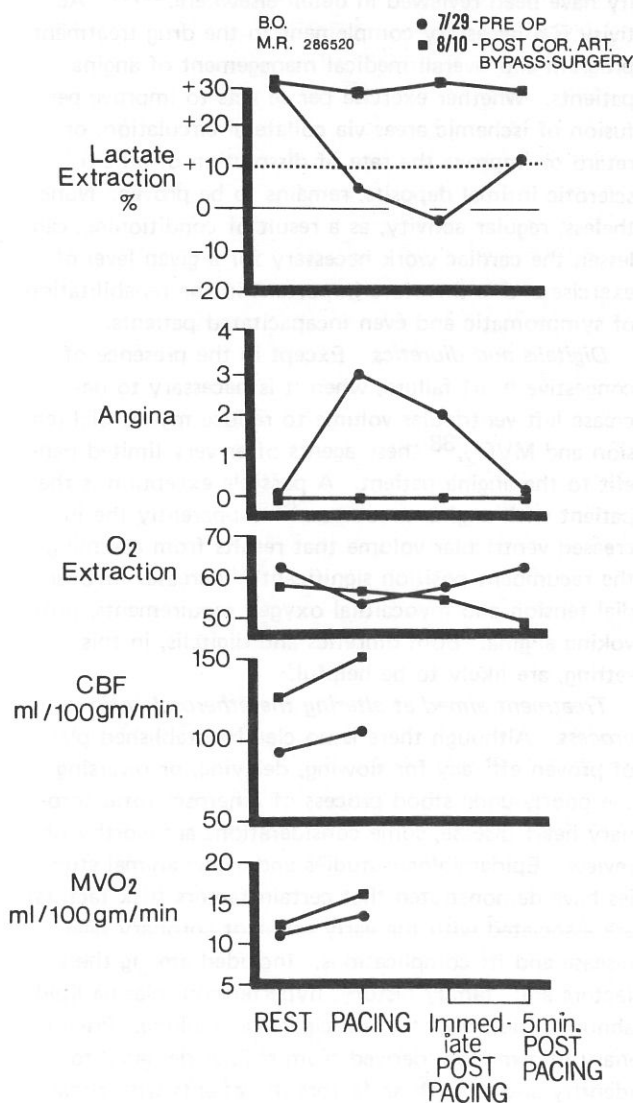


Figure 6.—Selective right coronary arteriogram of a patient with angina pectoris who presented 75% obstruction of a dominant right coronary artery (arrow in A). The patient's angina was refractory to both nitrates and beta blockade. Consequently, saphenous vein bypass was performed. When restudied 18 months later (B), the graft is functioning, and the patient is still angina-free.

and distal atherosclerotic coronary artery, remain to be examined.³⁴ While this procedure produces significant early benefits in relieving angina pectoris, we and others have observed an alarming number of postoperative myocardial infarctions and/or recurrent angina. Also, there are patients with completely occluded bypasses who remain angina-free. Until these questions are conclusively resolved, and, more importantly, until it can be demonstrated that this surgical approach extends the life of the angina patient, we prefer to reserve the procedure for patients who present incapacitating angina pectoris, intractable to medical management. Several possible exceptions to this indication include the so-called "critical" arteriographic lesion and some accelerated ischemic syndromes. We are eagerly awaiting a long-term comparison with respect to angina recurrence, subsequent myocardial infarction, and death rate of patients with bypass grafts and those treated by optimal, nonoperative medical means. A host of other

Figure 7.—The beneficial effects of coronary artery bypass surgery are illustrated by this preoperative (●) and postoperative (■) study of a 49-year-old-man with chronic refractory angina pectoris. Myocardial lactate extraction prior to surgery decreased confirming the presence of significant myocardial ischemia associated with angina pectoris in the pacing period. Although coronary blood flow (CBF) increased during the pacing period, the increase was certainly not appropriate for the changes in myocardial oxygen consumption (MVO₂). Postoperatively, myocardial lactate extraction remains normal during the pacing period. Angina is not elicited, and the coronary blood flow in both the resting and the pacing studies had heart rates identical to the preoperative study.



procedures devised for myocardial revascularization have not withstood this form of objective evaluation.³⁵

Several other surgical procedures, while not aimed at revascularization, play a role in the management of selected patients with ischemic heart disease. In general, these measures reduce ventricular tension by decreasing either left ventricular volume or pressure, thereby reducing MVO_2 . The procedures include excision of ventricular aneurysms, repair of perforated intraventricular septa in patients with refractive congestive heart failure or arrhythmias, aortic valve replacement in cases with severe aortic valve disease, and mitral valve replacement in patients with papillary muscle infarction.

Other Modes Of Treatment

Exercise. The beneficial effects of activity on patient well-being and improvement of functional capacity have been reviewed in detail elsewhere.^{36,37} Activity is a necessary complement to the drug treatment program and overall medical management of angina patients. Whether exercise per se acts to improve perfusion of ischemic areas via collateral circulation, or retard or improve the rate of dissolution of atherosclerotic intimal deposits, remains to be proven. Nonetheless, regular activity, as a result of conditioning, can lessen the cardiac work necessary for a given level of exercise and is therefore important in the rehabilitation of symptomatic and even incapacitated patients.

Digitalis and diuretics. Except in the presence of congestive heart failure, when it is necessary to decrease left ventricular volume to reduce myocardial tension and MVO_2 ,³⁸ these agents offer very limited benefit to the angina patient. A possible exception is the patient with angina decubitus.³⁹ Apparently the increased ventricular volume that results from assuming the recumbent position significantly increases myocardial tension and myocardial oxygen requirements, provoking angina. Both diuretics and digitalis, in this setting, are likely to be helpful.

Treatment aimed at altering the atherosclerotic process. Although there is no clearly-established plan of proven efficacy for slowing, delaying, or reversing the poorly-understood process of atherosclerotic coronary heart disease, some considerations are worthy of review. Epidemiologic studies and a few animal studies have demonstrated that certain factors (risk factors) are associated with the early onset of coronary heart disease and its complications. Included among these factors are: family history, hypertension, plasma lipid abnormalities, obesity, and cigarette smoking. Preliminary information, derived from studies designed to identify and alter these factors in patients with already

manifest coronary heart disease, indicates that a reduction of secondary atherosclerotic events may be possible.^{40,41} Additionally, there is some evidence to suggest that in peripheral atherosclerotic disease, an alteration of these factors can increase calf blood flow.⁴² Although this area remains controversial, the grave consequences of ischemic heart disease, as we have indicated in previous discussions, suggest that perhaps a more aggressive therapeutic approach is necessary. The choice of screening techniques and possible modification of certain factors in patients with clinically-manifest coronary artery disease, the so-called high-risk group, is even more difficult to evaluate.⁴³ Until an unfavorable influence on the mortality of patients with coronary atherosclerosis and angina pectoris can be conclusively demonstrated, we shall attempt to screen for and influence these factors in high-risk patients. The need for further critical examination of these considerations is urgent.

Conclusion

It is appreciated that the medical management of angina pectoris is based on a series of palliative measures aimed at reducing myocardial oxygen requirements and providing symptomatic improvement. In the absence of a suitable direct curative measure, the importance of this goal in a clinical setting needs to be reemphasized. Mounting evidence indicates that maximum utilization of available medical therapy can prevent or delay ischemic pain in approximately 80% of coronary artery disease patients. In addition to the reduction of incapacitating symptoms by a physiologic rational approach to cardiac ischemia, attempts to alter the underlying risk factors appear warranted. Direct coronary artery bypass surgery may be helpful in selected patients. This particularly useful and gratifying approach is of course aimed at reducing the overall mortality associated with angina pectoris.

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CENTRALIZED INTRAVENOUS ADDITIVE SERVICE

Centralized preparation of intravenous additives was initiated early this year at the Naval Hospital, Portsmouth, Va., in keeping with an emerging trend of drug therapy.

The new program, the second of its kind in the Navy, is conducted by the Naval Regional Medical Center's Pharmacy Service in conjunction with the hospital's Surgery Service. It provides all intravenous additives used by the hospital, in addition to other special fluids such as those used in conjunction with ophthalmic surgery and other problems affecting the eye requiring irrigation with antibiotic agents for surgical or special therapy patients.

Two registered pharmacists prepare the additives in a "clear air center" which has been specially outfitted using available equipment. An ultra-efficient air filtration system guarantees an uncontaminated environment and, consequently, a sterile product. The Central Intravenous Additive Service is expected to handle more than 100 units daily when fully operational.

Prior to initiation of this program, almost all intravenous additives used at the naval hospital were prepared by nurses and hospital corpsmen on the wards where they were needed. Centralized preparation alleviates their workload.—PAO, Naval Regional Medical Center, Portsmouth, Va.



SERVICE INITIATED — LT(jg) Dominick DePolo, Jr., a Naval Regional Medical Center (NRMC), Portsmouth, Va. pharmacist, demonstrates one operation in a new centralized intravenous additive service for RADM Joseph L. Yon (right) and CAPT Joseph T. Mullen. RADM Yon was the former Director/Commanding Officer of the NRMC and CO of the Naval Hospital, Portsmouth, when the service was initiated. CAPT Mullen is Chief of Surgical Service at the Naval Hospital in Portsmouth, Va. ☞

ADOLESCENT CLINIC

The Naval Hospital, Portsmouth, Va., has initiated a twice-a-week Adolescent Outpatient Referral Clinic to provide medical care for dependents between the ages of 12 and 18 years. Previously, these teen-agers were treated in adult clinics once they became too old for pediatric care.

The new service is headed by LCDR Ralph I. Lopez, MC, USNR. Dr. Lopez points out that one advantage of a clinic oriented toward teen-agers lies in the fact that medical problems in this age group are often unique, quite different from similar problems in children or adults.—PAO, Naval Regional Medical Center, Portsmouth, Va. ☞

From the Legal Editor.....

Revenue Ruling 72-123

The Internal Revenue Service recently issued Revenue Ruling 72-123, 1972-12 IRB6 (revoking Revenue Ruling 61-111, 1961-1 CUM BULL 9), indicating that 26 U.S.C. § 82, which was added to the Internal Revenue Code by Public Law 91-172; 83 STAT 579, requires that there shall be included in gross income any amount received or accrued, directly or indirectly, by an individual as a payment for or reimbursement of expenses of moving from one residence to another residence which is attributable to his employment. Therefore, temporary lodging allowances (dislocation allowances) paid to personnel of the Armed Forces in connection with a change in their permanent duty stations are includable in their gross income for tax years commencing after 31 December 1971.

Expenses in connection with the move such as traveling, meals, and lodging; meals and lodging while occupying temporary quarters in the general location of the new principal place of work during any period of 30 consecutive days following reporting; and any other expenses includable within the definition of moving expenses under 26 U.S.C. § 217(b), may be deducted as an expense item in reaching the taxable income figure. All personnel reporting to a command, or being transferred from a command, should be advised to maintain detailed and accurate records of such expenses in order to take advantage of the deduction provision provided by the Internal Revenue Code.

Medical Inquiry

On 3 March 1972 the U.S. Court of Military Appeals decided the case of *United States vs. Fisher* in which the court held that a medical doctor need not give an Article 31 UCMJ warning when the doctor's inquiry is "solely for treatment and diagnostic purposes."

In this case, the accused was brought into the emergency room and then taken to the intensive care unit of an Army hospital in a state of respiratory depression; his level of consciousness was described as "stuporous," and it was recited that he "was in immediate danger of suffering serious physical consequences." Thereafter, during a discussion with the attending physician, he admitted to having used cocaine. Later at his trial, over defense counsel's objection, the military judge ruled that "under the circumstances" the questions asked by the medical officer were necessary for "treatment and diagnostic purposes" and consequently concluded that Article 31 was inapplicable to the case. The accused was convicted for the wrongful use of cocaine. The Navy Court of Military Review upheld the action of the military judge, which resulted in a unanimous decision on the part of the Court of Military Appeals that "a medical doctor who questions an individual solely to obtain information upon which to predicate a diagnosis so that he can prescribe appropriate medical treatment or care for the individual is not performing an investigative or disciplinary function. Neither is he engaged in perfecting a criminal case against the individual. His questioning of the accused is not, therefore, within reach of Article 31."

The case is not significant as an indication of change in military law, but should be taken only as the latest pronouncement in this area. The military criminal law has never recognized the existence of a physician-patient privilege, in effect adopting the common law rule.

It does raise however, to me at least, the interesting question as to whether or not one with obviously impaired mental capacity, questioned under circumstances inherently coercive, may properly be put in a position which pits Constitutional rights against man's instinctive and inherent desire for self-preservation. That issue was not argued or addressed by the Court in *Fisher*, thus the answer must be left to a later pronouncement by the Court. ☛

TRAINING DENTAL ASSISTANTS

There is always a need for more assistance in the delivery of dental health care. Under the direction of Senior Dental Officer, CAPT Henry T. Mumme, DC, USN and the American Red Cross, the Dental Department at Parris Island, S.C. is co-sponsoring a Dental Assistant Training Program to provide this support.

Benefits accrue to the Dental Department, the patients being treated and those who receive this training. Additional direct assistance can be offered the dental officer who is providing the care. Patient treatment is enhanced and the trainee acquires a skill that may be utilized in the future for civilian employment. Through this program, more dental technicians come to participate in the preventive dentistry program, provide oral prophylaxis and operate dental radiographic equipment.

The program consists of 14 lectures given weekly

over a three-month period. An additional 140 hours of on-the-job training are required before the volunteers receive their certificates as dental assistants.

The only prerequisite for the course is the desire to learn. A high school diploma is not required. In general, the trainees receive instruction that is similar to that given at the Dental Technicians School in San Diego, Calif. All of the major disciplines of dentistry are considered in the course so that the trainees will be proficient in assisting the dentist in oral surgery, prosthodontics, restorative dentistry, endodontics, and periodontics.

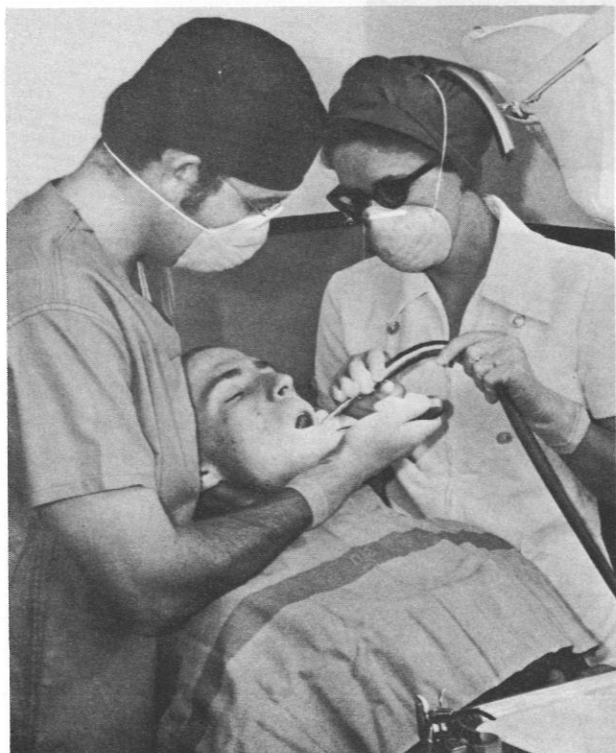
The Director of the program is CAPT R.T. Blackwell, DC, USN. He is assisted by CDR Stanley E. Pepek, DC, USN and the various dental specialists. MAJGEN Carl W. Hoffman is the Commanding General of the Marine Corps Recruit Depot at Parris Island.



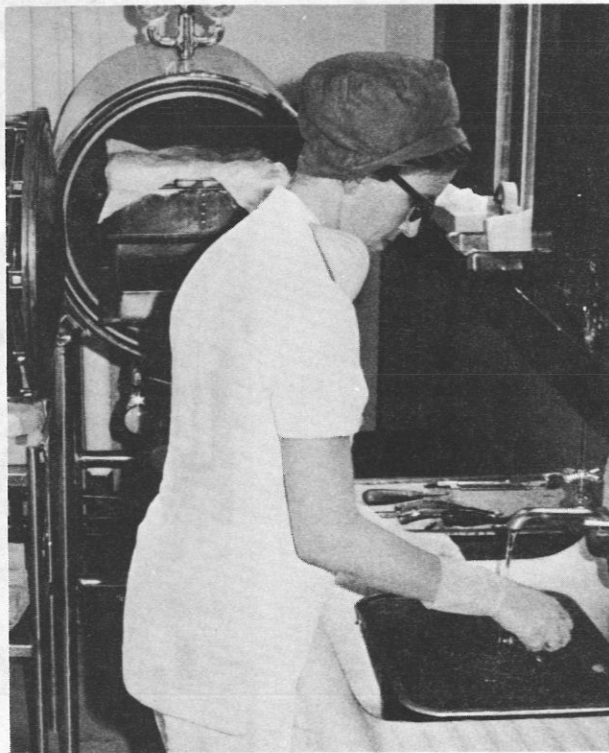
CAPT Wayne A. Nelson, DC, USN (left) delivers one of the 14 required lectures to dental technician trainees.



CDR S.E. Pepek, DC, USN (right) demonstrates the instrument tray layout for Marge Marrufo, a dental technician trainee.



A recruit receives examination for proposed oral surgery conducted by LT Ronnie H. Phillips, DC, USNR (right). He is assisted by June Medis (left), a Red Cross dental technician trainee.



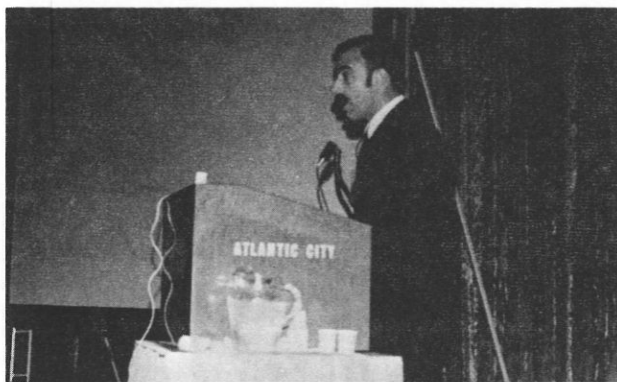
Scrubbing instruments is part of the program for Red Cross dental technician trainee, June Medis.

ACP Meeting, 1972

(Photos by U.S. NAVY MEDICINE)



Checking in from Nav Hosp Portsmouth, Va., (from left to right) are: CDR R.L. Mullin, MC, USN; LT J.A. Mihalevich, MC, USNR, and; CAPT J.T. Horgan, MC, USN.



LCDR Paul Cianci, MC, USN

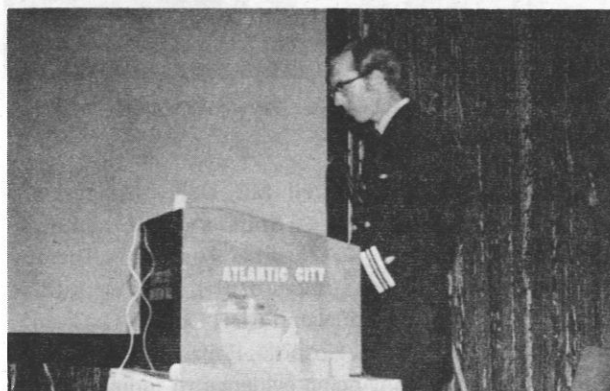
The fifty-third annual session of The American College of Physicians was held in Atlantic City, N.J., 17-21 April 1972.

Eight authoritative immunologists presented "State of the Art Lectures" at the beginning of each morning and afternoon session. These presentations were particularly worthwhile and were delivered by: Robert A. Good, MD, PhD, Regents' Professor of Pediatrics and Microbiology, University of Minnesota, Minneapolis, Minn; K. Frank Austen, FACP, Professor of Medicine Harvard Medical School, Boston, Mass; H. Sherwood Lawrence, FACP, Head, Infectious Disease and Immunology Division, New York University School of Medicine, New York, NY; John H. Vaughan, FACP, Chairman, Clinical Divisions, Scripps Clinic and Research Foundation, La Jolla, Calif; Robert S. Schwartz, MD, Professor of Medicine, Tufts University School of Medicine, Boston, Mass; Edward C. Franklin, MD, Professor of Medicine, New York University School of Medicine, New York, NY; Thomas E. Starzl, MD, PhD, Professor of Surgery, University of Colorado Medical Center School of Medicine, Denver, Colo; and J. Claude Bennett, FACP, Professor and Chairman, Dept. of Microbiology, and Director, Division of Clinical Immunology and Rheumatology, University of Alabama School of Medicine, Birmingham, Ala. Reflecting on the content of these papers, there can be no doubt that immunology has come a long way in the past decade.

LCDR Paul Cianci, MC, USN delivered a paper on the "Role of Free Fatty Acids in Growth Hormone Regulation During Fasting," authorship of which he shared with Richard E. Reitz, MD; Harold V. Werner, MD; and Richard L. Weinstein, MD; Clinical Investigation Center, Naval Hospital Oakland, and Department of Medicine, University of California, San Francisco, Calif. LCDR Cianci reported that nicotinic acid suppression of normal free fatty acid levels during the fed state of five healthy adult males resulted in no rise in

plasma levels of growth hormone. Nicotinic acid suppression of elevated free fatty acid levels during fasting promoted a marked rise in plasma growth hormone levels. Plasma glucose remained unchanged and cortisol levels did not increase during nicotinic acid administration. Elevated plasma levels of growth hormone were attributed to enhanced pituitary secretion and no decrease in metabolic clearance rate of growth hormone was observed. A possible feedback role of free fatty acids in the regulation of growth hormone secretion in fasting man was suggested.

LCDR William Jennings, MC, USNR, returned from active duty in Taipei, Taiwan to present: "Peripheral Vascular Disease in Diabetics — an Angiographic

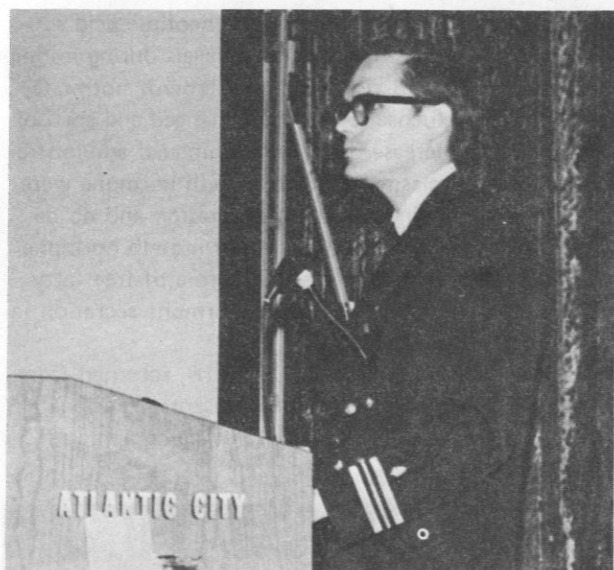


LCDR William Jennings, MC, USNR

Study," by W. Jennings, MD; Fred W. Whitehouse, FACP; and Roger F. Smith, FACS; Departments of Medicine and Surgery, Henry Ford Hospital, Detroit, Mich. On the basis of reported findings in a group of 102 diabetics that underwent translumbar aortograms during 1965-1968, internists were urged to seriously consider angiography and angioplasty in the management of diabetic patients with symptomatic peripheral vascular disease.



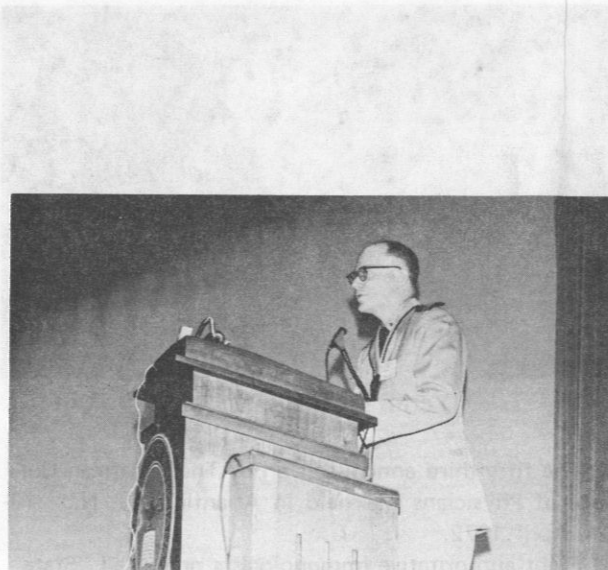
The Surgeon General (center) as an attentive attendee, caught from behind.



LCDR Raymond L. Farrell, MC, USN

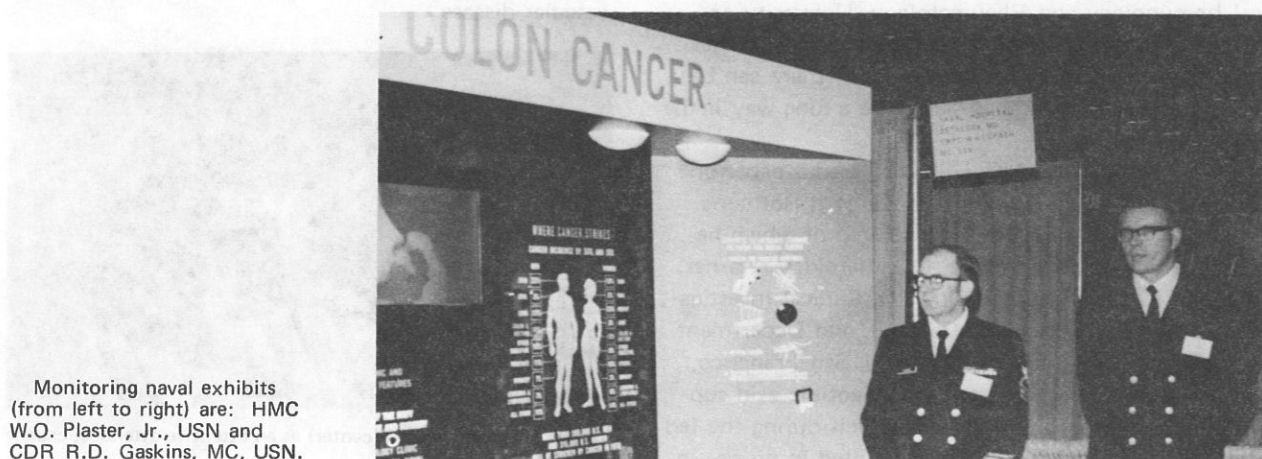
LCDR Raymond L. Farrell, MC, USN (Member) presented his paper, "Cholinergic Stimulation of the Lower Esophageal Sphincter — A Possible Advance in Therapy of Heartburn." Fellow authors of the paper were CDR Gerald T. Roling, MC, USN and CDR Donald O. Castell, MC, USN, FACP; Naval Hospital, Philadelphia, Pa. Dr. Farrell presented convincing evidence to indicate that the cholinergic agent bethanechol chloride raises lower esophageal sphincter pressure when administered subcutaneously and orally in normal subjects and in patients with sphincter incompetence. A potential role for cholinergic agents in therapy of symptomatic gastroesophageal reflux was proposed by this interesting report.

LCDR Otto T. Nebel, MC, USN presented a paper entitled, "Fat Inhibition of the Lower Esophageal Sphincter: A Mechanism for Fatty Food Intolerance,"

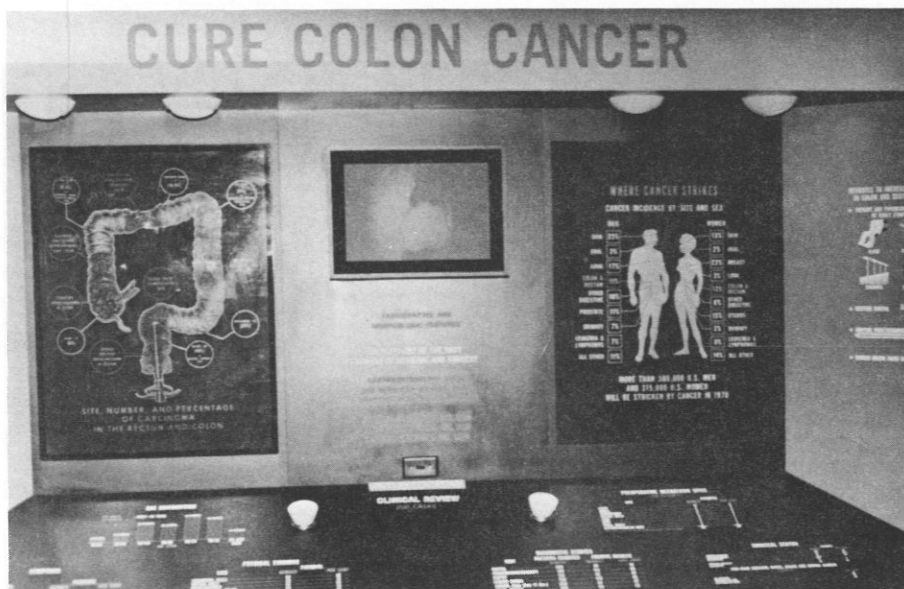


LCDR Otto T. Nebel, MC, USN

coauthored with CDR Donald O. Castell, FACP; Naval Hospital, Philadelphia, Pa. The report elucidated changes in lower esophageal sphincter strength after food ingestion and offered the following conclusions based on well-presented data: fat-induced inhibition of lower esophageal sphincter pressure provides a more sensitive index of sphincter competence, calorie for calorie, than does protein stimulation of increased sphincter pressure; fat attenuates the effect of a maximal pentagastrin stimulus to the lower esophageal sphincter; fat-induced lower esophageal sphincter incompetency can be effectively combated by gastric alkalinization in the form of antacids. The logical relation to "heartburn" following fatty food ingestion, and antacid therapy in the treatment of reflux symptoms, was gratifying to clinicians in the audience.



Monitoring naval exhibits (from left to right) are: HMC W.O. Plaster, Jr., USN and CDR R.D. Gaskins, MC, USN.



"Cure Colon Cancer" Exhibit



"Dermatoses in Vietnam" Exhibit

Two splendid Scientific Exhibits were offered by the U.S. Navy Medical Department and were monitored by CDR R.D. Gaskins, MC, USN and HMC William O. Plaster, Jr. "Cure Colon Cancer" by CAPT W.H. Lukash, MC, USN; LCDR R.B. Johnson, MC, USN and CDR M.F. Fornes, MC, USN, emphasized that the colon cancer survival rate can be further improved by stressing continued education for the patient and physician to achieve earlier detection of potentially curable malignancy. The exhibit was sponsored by BUMED.

"Dermatoses in Vietnam," authored by CDR T.E.

Carson, MC, USN, Naval Hospital Oakland, Calif, drew attention of many attendees interested in this unique exhibit on troublesome dermatoses encountered in Southeast Asia.

Among the enjoyable social amenities were: a "No-Host Cocktail Party" for USN attendees and their guests, engineered by CAPT W.J. Jacoby, Jr, MC, USN (Rear Admiral Selectee) at the Holiday Inn on Tuesday evening, 18 April, and; a U.S. NAVY MEDICINE dinner party for the faithful "Corner Authors" from Naval Hospital Philadelphia, on Wednesday evening 19 April at the Shelburne Hotel.

(No-Host) Navy Cocktail Party



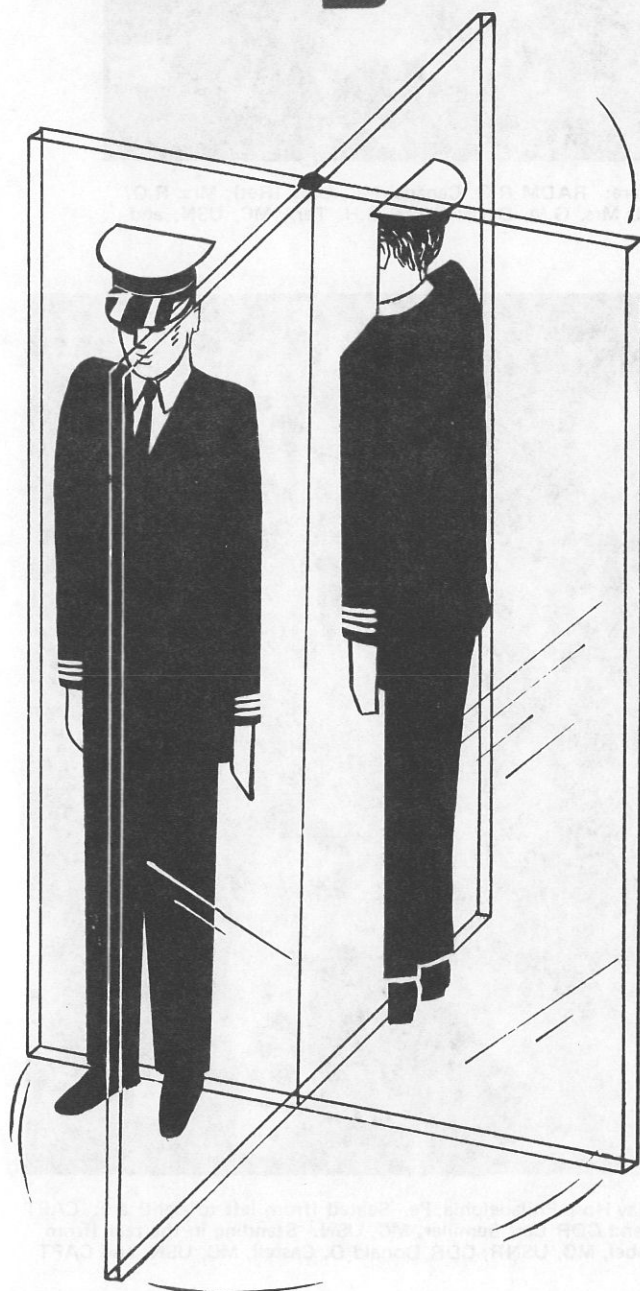


Lending charm to the Navy Party (from left to right) are: RADM R.O. Canada, MC, USN (Ret); Mrs. R.O. Canada; VADM G.M. Davis, MC, USN, Surgeon General; Mrs. G.M. Davis; CAPT G.H. Tarr, MC, USN; and Mrs. G.H. Tarr.



Our esteemed U.S. NAVY MEDICINE "Corner Authors" from Nav Hosp Philadelphia, Pa. Seated (from left to right) are: CAPT Richard Burningham, MC, USN; CDR Roger Chappelka, MC, USN and CDR Carl Bemiller, MC, USN. Standing in the rear (from left to right) are: LCDR Ray Farrell, MC, USN; LCDR Otto T. Nebel, MC, USNR; CDR Donald O. Castell, MC, USN; and CAPT William J. Jacoby, Jr, MC, USN (Rear Admiral Selectee).

Coming and Going



RADM W.P. ARENTZEN, MC, USN

From: Dep Dir, Navy Regional Medical Center,
Portsmouth, Va.

To: Dir/CO Navy Regional Medical Center,
Portsmouth, Va. (Apr)

RADM J.P. ARTHUR, DC, USN

From: Inspector General, Dental, BUMED

To: Asst Chief for Dentistry, BUMED (Jul)

RADM R.E. FAUCETT, MC, USN

From: Asst Chief for Research and Military
Medical Specialties, BUMED

To: CO, Nav Hosp Oakland, Calif. (Jun)

RADM W.H. HAGERMAN, JR., DC, USN

From: CO, NAVDENCLINIC, Camp Pendleton,
Calif.

To: CO, Naval Graduate Dental School, NNMC,
Bethesda, Md. (Aug)

RADM A.K. KAIRES, DC, USN

From: Professional Branch, Dental Division,
BUMED

To: Inspector General, Dental, BUMED (Jul)

RADM H.P. MAHIN, MC, USN

From: CO, Nav Hosp Oakland, Calif.

To: Inspector General, Medical, BUMED (Jul)

RADM R.D. NAUMAN, MC, USN

From: CO, Nav Hosp Memphis, Millington, Tenn.

To: Flt Surgeon, CINCLANTFLT (Jul)

RADM R.T. NORRIS, MC, USN

From: Inspector General, Medical, BUMED

To: Retirement

RADM E.C. RAFFETTO, DC, USN

From: Asst Chief for Dentistry, BUMED

To: Retirement (Jul)

RADM H.G. STOECKLEIN, MC, USN

From: Flt Surgeon, CINCLANTFLT

To: CO, Nav Hosp San Diego, Calif. (Jun)

RADM H.D. WARDEN, MC, USN

From: CO, Nav Hosp San Diego, Calif.

To: Retirement (Jul)

RADM J.L. YON, MC, USN

From: Dir/CO, Navy Regional Medical Center,
Portsmouth, Va.
To: Retirement (Apr)

CAPT D.C. BEER, MC, USN

From: CO, Nav Hosp Naples, Italy
To: CO, Nav Hosp Memphis, Millington, Tenn.
(Jul)

CAPT L.T. BROWN, MC, USN

From: CO, Nav Hosp Philadelphia, Pa.
To: Retirement (Aug)

CAPT D.R. BUECHEL, MC, USN

From: Nav Hosp San Diego, Calif.
To: CO, Nav Hosp Roosevelt Roads, P.R. (Jul)

CAPT M.C. CARVER, MC, USN

From: Nav Hosp Patuxent River, Md.
To: CO, Nav Hosp Patuxent River, Md. (Jul)

CAPT M.D. COURTNEY, MC, USN

From: CO, Naval Aerospace Medical Institute,
NAMC, Pensacola, Fla.
To: Staff, COMNAVAIRPAC (Jul)

CAPT G.E. CRUFT, MC, USN

From: XO, Nav Hosp San Diego, Calif.
To: CO, Nav Hosp Philadelphia, Pa. (Jul)

CAPT W.L. DARNALL, JR., DC, USN

From: CMC Hdqtrs, Wash., D.C.
To: CO, NAVDENCLINIC, Camp Pendleton,
Calif. (Jul)

CAPT J.J. DEMPSEY, MC, USN

From: CO, Nav Hosp Yokosuka, Japan (Jul)
To: Retirement (Sep)

CAPT A.J. DRAPER, MC, USN

From: CO, Nav Hosp Newport, R.I.
To: Navy Regional Medical Center, San Diego,
Calif. (Jul)

CAPT R.C. DRIPS, MC, USN

From: Nav Hosp Great Lakes, Ill.
To: CO, Naval Dispensary, San Francisco,
Calif. (Jul)

CAPT R.A. FISICHELLA, MC, USN

From: CO, Nav Hosp Portsmouth, N.H.
To: Dep Dir, Navy Regional Medical Center,
San Diego, Calif. (Jul)

CAPT P.O. GEIB, MC, USN (RADM Selectee)

From: CO, Nav Hosp Camp Lejeune, N.C.
To: Asst Chief for Research and Military Medical
Specialties BUMED (Aug)

CAPT W.J. GREEN, JR., MSC, USN

From: Nav Hosp Camp Lejeune, N.C.
To: CO, Naval School of Health Care Administra-
tion, NNMC, Bethesda, Md. (Jun)

CAPT A.A. HELGERSON, MC, USN

From: Navy Regional Medical Center, Portsmouth,
Va.
To: CO, Nav Hosp Key West, Fla. (Jul)

CAPT J.C. HODGES, JR., MC, USN

From: CO, Nav Hosp Key West, Fla.
To: CO, Nav Hosp Beaufort, S.C. (Jul)

CAPT K.C. HOERMAN, DC, USN

From: CO, Naval Dental Research Institute, Great
Lakes, Ill.
To: Retirement (Feb)

CAPT P. KAUFMAN, MC, USN

From: Chief of Professional Services, Nav Hosp
Bethesda, NNMC, Md.
To: CO, Nav Hosp Jacksonville, Fla. (Jul)

CAPT H.J. KEENE, DC, USN

From: Naval Dental Research Institute, Great
Lakes, Ill.
To: CO, Naval Dental Research Institute, Great
Lakes, Ill. (Feb)

CAPT H.O. KRETZSCHMAR, MC, USN

From: Dir Physical Qualifications & Medical
Records Div, BUMED
To: CO, Nav Hosp Naples, Italy (Jun)

CAPT R.C. LANING, MC, USN

From: XO, Nav Hosp Great Lakes, Ill.
To: CO, Nav Hosp Yokosuka, Japan (Jul)

CAPT C.W. LEWIS, JR., MC, USN

From: CO, Nav Hosp Jacksonville, Fla.
To: Dep Dir, Navy Regional Medical Center,
Portsmouth, Va. (Jul)

CAPT W.M. LONERGAN, MC, USN

From: XO, Nav Hosp Portsmouth, Va.
To: CO, Nav Hosp Charleston, S.C. (Jul)

CAPT J.A. LONG, MC, USN

From: CO, Nav Hosp Guantanamo Bay, Cuba
To: Senior Medical Officer, NTC Bainbridge,
Md. (Jul)

CAPT E.D. LOWEECEY, MC, USN

From: Naval Advisory Group, MACV, Saigon
To: CO, Nav Hosp Camp Pendleton, Calif. (Jun)

CAPT R.J. MARTIN, MC, USN

From: CO, Nav Hosp Patuxent River, Md.
To: Retirement (Jul)

CAPT G.J. McCLARD, MC, USN

From: Nav Hosp Guantanamo Bay, Cuba
To: CO, Nav Hosp Guantanamo Bay, Cuba
(Jul)

CAPT R.C. McDONOUGH, MC, USN

From: Dir, Aerospace Medicine Operations Div,
BUMED
To: CO, Naval Aerospace Medical Institute,
NAMC, Pensacola, Fla. (Jun)

CAPT E.R. PETERS, MC, USN

From: XO, Nav Hosp Philadelphia, Pa.
To: CO, Nav Hosp Camp Lejeune, N.C. (Jul)

CAPT G.M. RICKETSON, MC, USN

From: CO, Nav Hosp Camp Pendleton, Calif.
To: DMO, COM EIGHT, NSA New Orleans, La.
(Jul)

CAPT J.H. STOVER, JR., MC, USN

From: Dir, Fleet & Marine Corps Medical Support
Div, BUMED
To: CO, Nav Hosp Portsmouth, N.H. (Jul)

CAPT R.M. TENNILLE, MSC, USN

From: CO, Naval School of Health Care Adminis-
tration, NNMC, Bethesda, Md.
To: Retirement (Jun)

CAPT P.F. WELLS, II, MC, USN

From: CO, Nav Hosp Roosevelt Roads, P.R.
To: COMSERVPAC (Jul)

CAPT R.G.W. WILLIAMS, JR., MC, USN

From: CO, Nav Hosp Beaufort, S.C.
To: CO, Nav Hosp Newport, R.I. (Jul)

CAPT W.C. WOHLFARTH, JR., DC, USN

From: CO, Naval Graduate Dental School, NNMC,
Bethesda, Md.
To: Retirement (Oct) ☞

THE AMERICAN REGISTRY OF RADIOLOGIC TECHNOLOGISTS

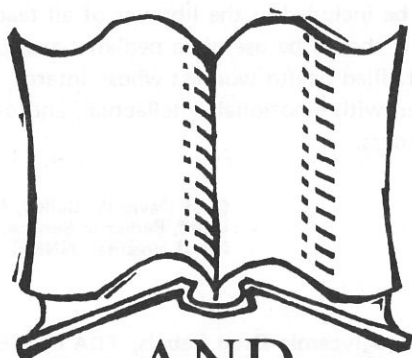
Beginning 1 Jul 1966, examination for registration in X-ray technology was restricted to graduates of programs of formal education approved by the Council on Medical Education of the American Medical Association (AMA). Although the three military services now have AMA-approved X-ray programs, many technologists commenced their training prior to approval of the military schools, and therefore, could not qualify under present requirements.

At its Feb 1972 meeting, the Registry Board of Trustees discussed the problems of military service-trained allied health personnel returning to civilian life who are ineligible for national certification. The Board was aware of the possible injustice in allowing examination for some service-trained X-ray technologists while denying examination to others whose training had been similar but took place prior to formal approval of the service school.

It was the decision of the Board that applications from technologists trained in the service prior to AMA approval of their service schools should be investigated to evaluate the equivalency of their program of training compared to that received by applicants who trained after approval of the program.

Military-trained X-ray technologists who are willing to take the trouble and expense of completing a formal application for examination will receive such an evaluation. No assurance of a prompt or favorable decision by the Board on any application can be given, but an objective evaluation of the qualifications of each applicant in terms of equivalency to those trained in the traditional manner, is offered. ☞

ABSTRACTS



AND REVIEWS

Fundamental Skills in Surgery, by Thomas F. Nealon, Jr., M.D., 2nd ed., 237 pp, 396 illus., \$11.75, Philadelphia, W.B. Saunders Co., 1971.

This book describes "procedures which a beginning surgeon might be expected to perform . . . whether or not he had the benefit of watching them done by a more experienced surgeon." Broad content ranges from surgical knot tying to operating room conduct, regional anesthesia, specific organ systems and intravenous alimentation. Descriptions of therapeutic maneuvers are sketchy, with no references.

Medical students entering their first surgical rotation might find this book a convenient source of orientation for practical ward work but the surgical house officer can find better descriptions of minor procedures in standard texts of outpatient surgery. Clinical management of multifaceted surgical situations requires more complex knowledge.

LT Charles C. Haynie, MC, USNR
Naval Hospital, NNMCMC, Bethesda, Md.

Experimentally-Induced Intrabony Cysts in Dog Mandibles. Abstract by Research Work Unit MR005.20 — 6052. CDR K.W. Besley, DC, USN and LCDR J.P. McMahon, DC, USN.

Cystic lesions in the jaws are a relatively common pathologic entity and are treated without much difficulty unless they have attained a large size. There is no agreement as to the best method of treating these larger lesions. To properly evaluate methods it will be

necessary to develop cysts experimentally. The purpose of this study was to create cysts experimentally in dog mandibles by using implants of autogenous full-thickness skin grafts.

Through an intraoral approach, a mucoperiosteal-cortical flap was raised bilaterally in the edentulous mandibular molar areas, and recipient sites were prepared. Three types of implants were placed: full-thickness skin graft alone, full-thickness skin graft supported by a medical grade silicone disk, and the silicone disk alone. In all cases where the skin implant was used, the dermal surface was placed in apposition to the surrounding bone. Five dogs received only the skin graft implant on one side, and the skin with a silicone disk support, or the silicone disk alone, on the other side. Radiographs were taken six weeks postoperatively. At intervals of six, eight and 16 weeks, specimens were removed for radiographic, gross, and histologic examination.

Histologic analysis of the specimens showed a progression from early degeneration of the implants to final cyst formation in all cases where the skin graft implant alone was used. Although cysts were developed by the technique described, it is doubtful whether they were large enough to test methods of treatment. To obtain cysts large enough for use in testing, it will be necessary to extend the development period for longer than 16 weeks.

The Giromatic Contra-Angle in Root-Canal Preparation. Abstract by Research Work Unit MR005.20 — 6052. LCDR C.L. Sabala, DC, USN and LCDR M. Ervin, Jr., DC, USN.

The Giromatic contra-angle handpiece is a mechanically driven instrument developed to help the endodontist prepare root canals. European reports based on clinical impressions gained from the use of this instrument have been favorable, but there is need for an objective evaluation. The purpose of this study was to determine in vitro the effectiveness of the Giromatic with respect to time and acceptability.

Thirty extracted molars with a total of 90 canals were used. Two operators prepared the canals to a No. 35 file size. Half were hand filed, and half were prepared with a combination of serial enlargement with Giromatic broaches followed by hand instrumentation, as recommended by the manufacturer. Time for preparation was recorded to the nearest ½ minute. The canals were then examined by three investigators who had no prior knowledge of the method of preparation. The canals were rated as acceptable or unacceptable using established endodontic criteria.

It was found that the time necessary for preparation of each tooth with the Giromatic was about ten minutes, which was half the time required with hand instrumentation. The same percentage of acceptability was obtained with the Giromatic as was obtained with hand instrumentation. From these results it was concluded that the Giromatic may be a valuable adjunct in endodontics.

Lymphatic System of the Female Genitalia: The Morphologic Basis of Oncologic Diagnosis and Therapy, by Albert A. Plentl, Ph.D., M.D. and Emanuel A. Friedman, M.D. 1st ed., 257 pp, \$14.00, Philadelphia, W.B. Saunders Co., 1971.

This is the second volume in an ongoing series edited by Dr. Friedman entitled, "Major Problems in Obstetrics and Gynecology." The book is divided to cover each major area of clinical importance separately. A detailed description of the lymphatic system is presented. This information forms the basis of an extensive review of the pathologic characteristics, staging, modes of therapy and prognosis for each malignancy of the female genitalia.

The authors have condensed a wealth of information into a relatively small volume which is well written and amazingly easy to read. The bibliography is current and more than adequate. I would highly recommend this book for any teaching program or any facility dealing with gynecologic malignancies.

LCDR R.H. Radnich, MC, USN
OB-GYN Dept., Naval Hospital, Bethesda.

Behavioral Science in Pediatric Medicine, by Nathan B. Talbot, M.D.; Jerome Kagan, Ph.D. and Leon Eisenberg, M.D. 1st ed., 467 pp, \$17.00, Philadelphia, W.B. Saunders Co., 1971.

The authors have each written a chapter and have called on their colleagues in psychology and allied fields to produce the remaining six chapters. The chapter entitled "Social and Behavioral Causes and Consequences of Disease Among Children" should be required reading for all pediatricians. "Childhood Accidents and Injuries" sheds considerable light on this most common cause of morbidity and mortality. The remaining sections deal with various aspects of psychosocial development and its derangements; these would be of interest primarily to those who work with children.

The basic format, organization and printing are excellent except for numerous minor but annoying errors in spelling. The references are exhaustive and the index well organized.

Dr. Talbot, et al., have produced a current and provocative reference work that deals in depth with the psychosocial aspects of child health and development. It should be included in the libraries of all teaching services. It should be useful to pediatricians, psychologists and allied health workers whose interest focus on children with emotional, intellectual, and/or behavioral disorders.

CDR David W. Bailey, MC, USN
Chief, Pediatric Service,
Naval Hospital, NNMC, Bethesda.

Oral Hypoglycemic Drug Labels, FDA Drug Bulletin, Department of Health, Education, and Welfare, Rockville, Md., May 1972.

The most recent labeling for the sulfonylurea drugs and for phenformin, approved by the Food and Drug Administration, provides that these drugs are indicated in the treatment of adult-onset, non-ketotic diabetes mellitus only when the condition cannot be controlled adequately by diet and reduction of excess weight alone.

The labeling includes a SPECIAL WARNING which says:

"Diet and reduction of excess weight are the foundations of initial therapy of diabetes mellitus. When the disease is adequately controlled by these measures, no hypoglycemic drug therapy is indicated. Because of the apparent increased cardiovascular hazard associated with oral hypoglycemic agents, they are indicated in adult-onset, non-ketotic diabetes mellitus only when the condition cannot be adequately controlled by diet and reduction of excess weight alone, and when, in the judgment of the physician, insulin cannot be employed because of patient unwillingness, poor adherence to injection regimen, physical disabilities such as poor vision and unsteady hands, insulin allergy, employment requirements, and other similar factors."

This labeling and therapeutic regimen for diabetes mellitus are consistent with the therapeutic recommendations of the American Diabetes Association and the Council on Drugs of the American Medical Association, with which FDA consulted on the evaluation of the University Group Diabetes Program (UGDP) study.

The long-term UGDP study provided the basis for the labeling. That study suggested that the use of the sulfonylurea drug tolbutamide and the biguanide drug phenformin were associated with a greater incidence of cardiovascular mortality than diet alone, or than insulin plus diet.

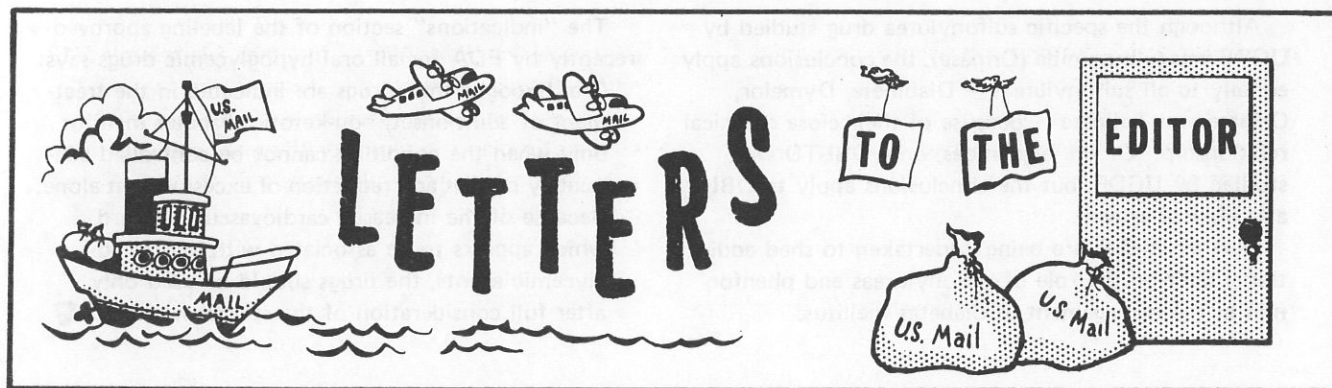
Although the specific sulfonylurea drug studied by UGDP was tolbutamide (Orinase), the conclusions apply equally to all sulfonylureas — Diabinese, Dymelor, Orinase and Tolinase — because of their close chemical relationship. Of the biguanides, only DBI-TD was studied by UGDP, but the conclusions apply to DBI and Meltrol as well.

Further studies are being undertaken to shed additional light on the role of sulfonylureas and phenformin in the management of diabetes mellitus.

The "indications" section of the labeling approved recently by FDA for all oral hypoglycemic drugs says: "Oral hypoglycemic drugs are indicated in the treatment of adult-onset, non-ketotic diabetes mellitus only when the condition cannot be controlled adequately by diet and reduction of excess weight alone. Because of the increased cardiovascular hazard which appears to be associated with oral hypoglycemic agents, the drugs should be used only after full consideration of the special warning." 🍀



HM3 Kenneth G. Norwood, USN was congratulated by LT Emery T. Dessoify, Officer-in-Charge of Physical Therapy, during reenlistment ceremonies held in a Hubbard tank at the Pensacola Naval Hospital where Norwood worked as a physical therapy technician. He subsequently attended the X-ray technician school at Bethesda, Md.—PAO, Naval Aerospace Medical Center, Pensacola, Fla. 🍀



To the Editor: I read with interest the article on the China Scene in U.S. NAVY MEDICINE, 59:32, May 1972. I would like to take mild exception to the statement, "... apparently the first Navy physician to re-enter China since 1945." I was the Senior Medical Officer in USS TANTALUS (ARL-27) while that ship was in Shanghai in Jan-Mar 1946 and while it was the station ship in Hankow, China, from Mar 1946 until I was returned to CONUS for separation in Aug 1946. I believe that REPOSE was in Tsingtao until sometime in late 1946 or early 1947.

Again, I would like to say that I enjoyed the article, because I saw some treatment being done with acupuncture. At the time I shook my head and suspected it was some form of hocus-pocus.

No doubt you will have heard from many others who have had duty in China later than Aug 1946.

CAPT A.P. Rush, MC, USN
Medical Dept., Naval Air Station,
Pensacola, Fla. 32508

CAPT Rush is our only correspondent on this point, to date, and his letter is appreciated. Some quick checking reveals that REPOSE entered the port of Shanghai on 30 Sept 1945 and spent the next 13 months moving from one buoy to another while handling Seventh Fleet sick and Naval Group China personnel. REPOSE sailed for San Francisco on 15 Oct 1946 and following overhaul, returned to take station 1 Mar 1947 in the Inner Harbor of Tsingtao, China, to serve as a base hospital for the Seventh Fleet. Shifting to Shanghai by 17 Mar 1949, REPOSE then took station in the Woosung River Entrance 21 April 1949 to provide refuge to American and British nationals as Communist Chinese endangered the foreign settlement at Shanghai. After debarking evacuees at Hong Kong, REPOSE departed for home on 25 Jun 1949 and was decommissioned 19 Jan 1950. She was assigned to the San Francisco Group, U.S. Pacific Reserve Fleet.

To the Editor: After retirement from my civilian practice of Pathology, while going through my books, I found some bound copies of the "BUMED NEWS LETTER." Thinking that the first copy of the NEWS LETTER might be of interest to you, I have made two copies of the first page and am enclosing them.

I want to congratulate you as Editor for the high quality of "U.S. NAVY MEDICINE," the big brother of our little "BUMED NEWS LETTER" begun nearly 40 years ago.

RADM W.W. Hall, MC, USN (Ret.)
4447 Marseilles Street
San Diego, Calif. 92107

RADM Hall modestly neglects to mention that the editor of the "BUMED NEWS LETTER" was CAPT W.W. Hall, MC, USN. We enjoyed the masthead subtitle — "A digest of timely information" — which graced the Vol. 1, No. 1 issue of Friday, 5 Mar, 1943. We suspect, Dr. Hall, that remarkably little has changed in the 40 years, but your kind words and encouragement are most welcome. There are those days when it seems that only another editor could possibly know!

To the Editor: Congratulations to Captain Donald Robinson, MC, USN on his excellent article, "Military Medicine — The Therapeutic Dilemma," and to you for publishing it in the May 1972 issue of U.S. NAVY MEDICINE. (The article was also abstracted in "NAVY TIMES.") The author has articulated the challenges of the near future with clarity and insight.

If the doctor draft ends as planned on 1 Jul 1973, the problems of health care delivery by doctors in uniform could obviously become critical, and help may be welcome from any available sources. One source which has been under-utilized in the past is the Naval Reserve. For the past two years, to his great credit, CAPT Wendell Johnson, now Director, Reserve Division in BUMED, has requested that reserve officers

spend their active duty time in needed, but unfilled billets. It would appear that in this day of computerization, when leaves, changes of duty station, and retirements can be quickly tabulated, much greater use of this resource could be made.

Another source of help might come from recently retired career medical officers willing to come back to duty for two to four weeks per year in their own specialty. Many of these are in teaching or group practice from which they can get away. It might be pointed out that the utilization of such officers would be relatively inexpensive since they are already receiving upwards of 50 percent of their pay.

Finally, as to recruitment, many of us who were

around during World War II feel that a large-scale V12 or ASTP type of scholarship approach for medical school deserves more consideration. The present scholarship plan is a plum for the man who gets one, but yields relatively small numbers of doctors, and is costly to the taxpayer in terms of service years they produce.

Again, congratulations on this excellent article.

CAPT Matt H. Backer, Jr., MC, USNR
Commandant's Representative and
Professor, Clinical OB-GYN,
St. Louis University School of Medicine,
St. Louis, Mo. 63145

SGLI PREMIUM RATES DROP 15%; ANNUAL SAVINGS OF \$12 MILLION

The Veterans Administration announced a 15 percent reduction in premium rates on Servicemen's Group Life Insurance (SGLI) which means savings of \$12 million annually for servicemen.

Administrator of Veterans Affairs Donald E. Johnson said nearly 2.9 million servicemen, who are insured for \$42.5 billion, will participate in the savings, effective July 1.

Johnson noted the reduction, the first since the SGLI program was established in 1965, became feasible because of continuing favorable mortality experience. Servicemen need not contact VA to take advantage of the reduced rates.

Before the reduction, servicemen paid one dollar a month for each \$5,000 of coverage. Thus, the maximum coverage of \$15,000 costs \$3.00 per month under the present rate. Effective July 1, the new rate for the full \$15,000 coverage will be \$2.55, for \$10,000, \$1.70, and for \$5,000, \$0.85 monthly.

All members of the Armed Forces are automatically insured under SGLI, and premiums are deducted from their pay unless they decline in writing to be insured. The maximum amount was raised from \$10,000 to \$15,000 in June 1970.

Members on full duty have protection for 120 days after separation. The group coverage can be replaced, regardless of health, by individual policies issued by 600 participating commercial companies if application is made within 120 days of separation.

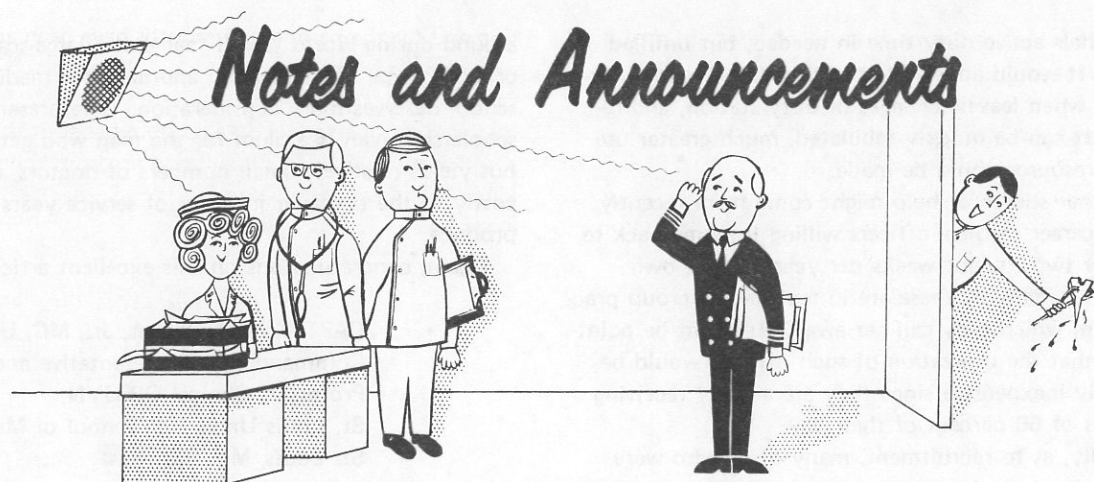
Rates for reservists, who are insured only during active duty training periods and associated travel, will be reduced from \$1.80 to \$1.50 annually for \$15,000 coverage.—AFPS, Washington, D.C.

VISITING SPECIALTY TEAMS

Implementation of the visiting-team concept for medical specialty care which takes the service to the patient has moved into high gear at the Tidewater Naval Regional Medical Center.

Six new part-time clinics staffed by specialists and back-up personnel from the Naval Hospital, Portsmouth, Va., have been established at the Admiral Joel T. Boone Clinic, Little Creek Naval Amphibious Base. Others are in the planning stage. Two have been added at the Norfolk Naval Station dispensary. Scheduled visits vary from twice-a-week to once-a-month.

Visiting specialty teams now conduct the following clinics at Little Creek: Third Trimester Prenatal; Pediatric Urinary Tract Infection; Pediatric Cardiology; General Surgery; Orthopedic; and Dermatology. Pediatric Cardiology and Surgical clinics have been added at the Norfolk Naval Station which previously had visiting specialists for third trimester prenatal care.—PAO, Naval Regional Medical Center, Portsmouth, Va.



URINE SURVEILLANCE PROGRAM

As you are aware, we have been directed to implement a program of urine surveillance of all military personnel for drug abuse. To accomplish this task, the Navy established five regional drug screening laboratories, each capable of screening large numbers of urine samples (5,000/week) for the more commonly abused drugs. The Navy laboratories are located at the Naval Hospitals in San Diego, Calif.; Oakland, Calif.; Great Lakes, Ill.; Portsmouth, Va.; and Jacksonville, Fla. These laboratories are identically manned and equipped, and utilize the same analytical and chemical screening procedures. The standardization of the screening laboratories was deemed essential to eliminate variations due to differences in the laboratories' capabilities.

While it is the purpose of the laboratories to identify possible drug abusers, they are not intended in any way to function in a medicolegal capacity. However, due to the sensitive nature of the laboratory results, it is essential that all means be taken to eliminate both false positive and false negative results. To accomplish this difficult task, the laboratories utilize the most sensitive and reliable analytical procedures available. In addition, all Navy screening laboratories use the bimodal approach to drug identification, that is, any sample found positive by screening procedures is confirmed by a different analytical method prior to being reported as positive. This approach virtually eliminates the possibility of a false positive result. As a further safeguard against false positive results, in any situation where there is doubt whether a sample is positive or negative, it is reported as negative.

Prior to discussing the individual screening procedures utilized in the Navy laboratories, certain basic

requirements should be pointed out. To be effective in detecting possible drug abusers by urine surveillance, the screening test must be capable of identifying drugs for a period of two to three days following the last administered dose. Since the levels of most drugs or drug metabolites present in the urine are extremely low, screening techniques must be highly sensitive, that is, capable of detecting microgram quantities accurately. It is also important that the screening technique be as specific as possible to eliminate false results.

The most commonly abused drugs can be grouped into three pharmacologic classes as follows:

<i>Sedatives/Hypnotics</i>	<i>Stimulants</i>	<i>Narcotic Alkaloids</i>
Amobarbital	Amphetamine	Heroin/morphine
Butabarbital		Codeine
Hexabarbital	Methamphetamine	Methadone
Pentobarbital		Propoxyphene
Secobarbital	Cocaine	hydrochloride
Phenobarbital		Meperidine

All of the above-mentioned drugs can be detected at levels of one microgram per milliliter of urine, or less, by the Navy's drug screening laboratories. Many other drugs can be identified via this screening procedure; however, because these drugs are not commonly abused, their identification does not constitute a positive report from the laboratory. While most agents commonly abused can easily be identified, a number of drugs cannot be identified from biological fluids; present analytical tests are not sensitive enough to detect these substances. These drugs are the highly potent hallucinogenic agents such as LSD and psilocybin, which are administered in microgram quantities. Marijuana also falls into this class of nondetectable drugs.

As previously mentioned, the Navy screening labora-

tories are set up to detect drugs by a variety of analytical procedures. For example, two techniques are routinely utilized to detect the presence of morphine in urine. The first technique is a spectro-fluorometric assay and the second is the FRAT (Free Radical Assay Technique) test. This latter test was developed by the SYVA Corporation in Palo Alto, Calif. Basically the test is an immuno-assay utilizing a spin-labelled antibody developed against a morphine conjugate. This method is highly sensitive and detects the presence of morphine (or heroin) in submicrogram quantities. Its main advantage is that the test is very rapid, taking less than a minute. At present, the technique can only detect morphine derivatives, but it is hoped that in the near future the test will be expanded to include other drugs such as amphetamines and barbiturates. A disadvantage is that the antibodies are not entirely specific and therefore interact with various other substances to give false positive results. This lack of specificity requires that the FRAT screening test be accompanied by a very sensitive confirmatory procedure.

For other drugs, such as barbiturates, amphetamines, and other narcotic alkaloids, gas-liquid chromatography is routinely used for the screening test. In addition each laboratory has the capability of performing urine screening by thin layer chromatography. Its main advantage is that it requires no special instrumentation and accordingly, is especially effective as a backup to the other screening techniques. To confirm all positive results obtained by the other screening tests, the Navy laboratories use a separate and highly specific gas chromatography procedure. It is estimated that this screening procedure will be effective in detecting and identifying the commonly used drugs of abuse for a period of at least two to three days following the last administration.

To assure uniform and reliable testing throughout the armed services, all laboratories are routinely checked by a tri-service laboratory drug detection quality control program. This quality control program is coordinated by the Armed Forces Institute of Pathology which is responsible for the preparation of urine specimens containing drugs of abuse, shipping of specimens for testing in such a manner as not to be identified as quality control samples, receiving and collating results, and notifying appropriate agencies of the results. Navy Drug Screening Laboratories receive approximately 20 quality control samples per week which contain varying concentrations of the common drugs of abuse as well as normal urine samples as negative controls. At present, based on the quality control program, the five Navy laboratories are performing with an overall accuracy of 94.6% and have a 0% false positive error.

All of the drug testing facilities are now in full opera-

tion and for the past several months have been actively screening selected Navy and Marine Corps personnel. This program has been expanded to include all Navy and Marine Corps personnel on a random basis. It is hoped that the planned urine surveillance program will not only identify the hard-core abuser, but will also act as a deterrent to those individuals who are experimenting with drugs.

s/G.M. Davis, Surgeon General
VADM, MC, USN

HISTORICAL FUND

The NAVY MEDICAL DEPARTMENT HISTORICAL FUND, with representation from the Medical Corps, Dental Corps, Medical Service Corps, and Nurse Corps was created to acquire and maintain items of historical significance to the Medical Department including portraits designed to perpetuate the memory of distinguished members of the Medical Department. Memorial objects acquired by the Fund are displayed in the Bureau or at the National Naval Medical Center in Bethesda, Md.

Medical Department personnel, active and inactive, are invited to make voluntary contributions to the Fund. All monies received are deposited in Washington, D.C. financial institutions to the credit of the Navy Medical Department Historical Fund and are subject to semiannual audit for correctness of receipt and disbursement. Expenditures are made only as approved by the Committee for its stated objectives.

If you wish to contribute, please send your check or money order (payable to "Navy Medical Department Historical Fund") to: Treasurer, N.M.D. Historical Fund, Bureau of Medicine and Surgery (Code 46), Department of the Navy, Washington, D.C. 20390.

INSERVICE CONSULTANT/ LECTURER PROGRAM

In order to establish a regular program which will provide for utilizing the expertise of qualified Medical Department active duty personnel in connection with Medical Dept. education and training programs, BUMED has expanded its Inservice Lecturer Program. (See U.S. NAVY MEDICINE 59:50, Feb 1972, and BUMED INSTRUCTION 1500.11.)

These visits by expert professional personnel have provided fresh viewpoints and have served as an excellent stimulus for both the visitor and the host activity. The program involves occasional exchange visits of various Chiefs of Service within reasonable proximity to other naval hospitals and medical activities, for one

or two-day periods, to conduct ward rounds, teaching seminars, chaired departmental conferences, and consultations and clinics for unusual cases. Participation by all naval hospitals is encouraged.

With a view toward increasing the quality of patient care by enhancing the depth and caliber of existing education and training programs, BUMED shall defray the related TEMADD costs for this effort, subject to the availability of centrally-managed education and training resources. Annual estimates shall be requested from participating activities for planning purposes as may be required.

The following procedure should be followed to implement the program:

a. The selection of the inservice consultant/lecturer shall be initiated by the activity which desires the teaching/consultative services.

b. When a visit has been mutually agreed upon, the requesting command shall send a letter of request to

BUMED (Code 316) via the Commanding Officer of the consultant/lecturer no later than four weeks before the proposed visit. This letter must contain the:

- (1) Name, rank, file number/designator, and social security number of the consultant/lecturer.
- (2) Inclusive dates of TEMADD period.
- (3) Purpose of the requested visit.

c. By endorsement to the Bureau, the consultant/lecturer's Commanding Officer shall make a statement as to his or her availability for the requested period.

d. Provided the consultant/lecturer's services can be spared for the requested period, the Bureau will issue a fund authorization letter to his Commanding Officer for TEMADD orders issuance and inform the requesting command.

Should new ideas or methods developed under this program be adopted, a short report will be submitted to BUMED (Attn: Code 31) for possible dissemination and use at other naval activities. — Code 316, BUMED. 4

POSTGRADUATE SHORT COURSES IN CONTINUING EDUCATION

The following postgraduate professional short courses will be conducted by the Armed Forces Institute of Pathology or the Army Medical Department during Fiscal Year 1973. The Bureau of Medicine and Surgery has been allocated a limited number of quotas for each course.

Eligible Medical Department officers desiring to attend should submit their requests in accordance with applicable Directives, in time to reach BUMED at least eight weeks prior to the convening date of the course desired. — Code 3161, BUMED.

COURSES	INSTALLATION	DATE
Accident Pathology	* Armed Forces Institute of Pathology, Wash., D.C.	7-9 May 1973
Administration for Hospital Food Service Systems	Walter Reed Army Institute of Research, WRAMC, Wash., D.C.	14-18 Aug 1972
Advanced Clinical Pathology of the Oral Regions	Army Institute of Dental Research, WRAMC, Wash., D.C.	5-9 Feb 1973
Advanced Electron Microscopy	* Armed Forces Institute of Pathology, Wash., D.C.	27 Nov – 1 Dec 1972
Aerospace Pathology	* Armed Forces Institute of Pathology, Wash., D.C.	29-31 Jan 1973
Application of Histochemistry to Pathology	* Armed Forces Institute of Pathology, Wash., D.C.	8-12 Jan 1973
AFIP Course in Oral Pathology (Annual)	* Armed Forces Institute of Pathology, Wash., D.C.	19-23 Mar 1973

<i>COURSES</i>	<i>INSTALLATION</i>	<i>DATE</i>
AFIP Lectures (Annual)	* Armed Forces Institute of Pathology, Wash., D.C.	26-30 Mar 1973
Armed Forces OB/GYN Seminar	Madigan General Hospital Tacoma, Washington.	16-20 Oct 1972
Current Concepts of Restorative Dentistry	Army Institute of Dental Research, WRAMC, Wash., D.C. Letterman General Hospital San Francisco, Calif.	11-15 Sep 1972 4-8 Dec 1972
Current Management of Trauma	Brooke General Hospital BAMC, Fort Sam Houston, Tex.	5-9 Mar 1973
Current Trends in Cardiovascular Disease	Brooke General Hospital BAMC, Fort Sam Houston, Tex.	16-18 May 1973
Forensic Dentistry	* Armed Forces Institute of Pathology, Wash., D.C.	2-6 Oct 1972
Forensic Pathology	* Armed Forces Institute of Pathology, Wash., D.C.	13-17 Nov 1972
Gary P. Wratten Surgical Symposium	Walter Reed General Hospital WRAMC, Wash., D.C.	9-11 Apr 1973
Genitourinary Pathology	* Armed Forces Institute of Pathology, Wash., D.C.	15-19 Jan 1973
Gynecological Pathology	* Armed Forces Institute of Pathology, Wash., D.C.	30 Oct — 3 Nov 1972
James C. Kimbrough Urological Seminar	Fitzsimons General Hospital Denver, Colorado	31 Oct — 2 Nov 1972
Neuropathology	* Armed Forces Institute of Pathology, Wash., D.C.	22-26 Jan 1973
Ophthalmic Pathology	* Armed Forces Institute of Pathology, Wash., D.C.	11-15 Sep 1972; 5-9 Mar 1973
Oral Diagnosis and Therapeutics	Army Institute of Dental Research, WRAMC, Wash., D.C.	23-27 Apr 1973
Oral Surgery	Army Institute of Dental Research, WRAMC, Wash., D.C. Letterman General Hospital San Francisco, Calif.	8-12 Jan 1973 2-6 Apr 1973
Orthopedic Pathology (for Pathologists)	* Armed Forces Institute of Pathology, Wash., D.C.	11-17 Feb 1973

<i>COURSES</i>	<i>INSTALLATION</i>	<i>DATE</i>
Otolaryngology Basic Science Course	* Armed Forces Institute of Pathology, Wash., D.C.	2 Apr – 11 May 1973
Pathology of Laboratory Animals	* Armed Forces Institute of Pathology, Wash., D.C.	18-22 Sep 1972
Pathology of the Aquatic Environment	* Armed Forces Institute of Pathology, Wash., D.C.	25-27 Apr 1973
Periodontics	Letterman General Hospital San Francisco, California Army Institute of Dental Research, WRAMC, Wash., D.C.	26 Feb – 2 Mar 1973 12-16 Mar 1973
Preventive Dentistry	Army Institute of Dental Research, WRAMC, Wash., D.C.	16-20 Oct 1972
Prosthodontics	Letterman General Hospital San Francisco, Calif. Army Institute of Dental Research, WRAMC, Wash., D.C.	16-20 Oct 1972 13-17 Nov 1972
Uniformed Services Pediatric Seminar	Marine Memorial Club San Francisco, Calif.	12-16 Mar 1973

*Applicants requesting courses sponsored by the Armed Forces Institute of Pathology shall forward a copy of their request to the Director, Armed Forces Institute of Pathology (AFIP-EDE), Washington, D.C. 20305. ☞

AMSUS CALL FOR PAPERS

The Association of Military Surgeons of the United States has extended an invitation to reservists to submit scientific papers for possible presentation at the Association meeting in San Antonio, Texas in December 1972. The papers may be of any specialty interest and should be submitted as soon as possible to AMSUS, 1500 Massachusetts Ave., N.W. Washington, D.C. 20005.

Emphasizing the theme "Federal Medicine: A National Resource," medical departmental officers and civilians of the armed forces, VA, and Public Health Service will convene for the 79th Annual Meeting of AMSUS to be held at the Convention Center, San Antonio, Texas on 10-13 Dec 1972.

This will be the first time since 1949 that AMSUS has held its annual meeting outside Washington, D.C. — Code 36, BUMED. ☞

DRUG EDUCATIONAL FILM

Fifty-seven copies of the drug abuse educational film, "What Did You Take?" has been purchased by

the Bureau of Medicine and Surgery and is applicable to all naval medical and paramedical personnel. Copies of the film will soon be circulated through the district medical officers, CINCPAC/CINLANT medical officers, Tidewater Regional Medical Center, and the Headquarters, United States Marine Corps.

"What Did You Take?" was filmed in the emergency room at the Beth Israel Hospital in New York and deals with actual drug abuse emergencies. Through 30 minutes of high intensity cineme verite, the film is designed to acquaint the physician and paramedical personnel with the signs, symptoms and emergency treatment of patients under the influence of opiates, hallucinogens, sedatives and stimulants.

The film is highly recommended for all naval medical and paramedical personnel. Additional prints of the film will be available from the Film Library, Naval Medical School, National Naval Medical Center, on a short-term basis. — LCDR T.W. Hard, MC, USN; Head, Media Dept., Nav Med School, NNMCMC, Bethesda, Md. 20014. ☞

CHARITY GUILD NAMED FOR CAPT DAUSER

In 1965 a group of former members of the U.S. Navy Nurse Corps organized a guild to support the Mary Bridge Children's Hospital in Tacoma, Wash. The guild was recently renamed the Captain Sue S. Dauser Guild in memory of the fifth Superintendent of the U.S. Navy Nurse Corps and the first woman in the Navy to be promoted to the rank of Captain. Captain Sue S. Dauser, NC, USN, died 8 Mar 1972 in Anaheim, Calif.

Sue S. Dauser was born on 20 Sep 1888 in Anaheim, Calif. After attending Stanford University for two years, she then attended the California School of Nursing from which she graduated in 1914. She remained there in charge of surgery until Sep 1917 when she was appointed a Naval Reserve Nurse. Miss Dauser commenced active duty on 16 Oct 1917 attending a course of instruction at the Naval Hospital, San Diego. Upon completion of this course, she was appointed Chief Nurse, U.S. Naval Reserve on 28 Nov 1917 and was placed in charge of nursing activities, Naval Base Hospital No. 3, Philadelphia, Pa.

Her appointment as Reserve Nurse was terminated on 10 July 1918; the following day she was appointed, successively, Nurse, U.S. Navy, and Chief Nurse, U.S. Navy. She continued her duties with Naval Base Hospital No. 3 when it was ordered to Edinburgh, Scotland to replace a British Naval Hospital Unit. Miss Dauser remained in Scotland until after the armistice when she was ordered to Brest, France for temporary duty while awaiting transportation back to the U.S.

Shortly after her return to the U.S. she was ordered to duty in charge of the nursing activities at the Naval Hospital, San Diego. Subsequently she was assigned to duty aboard the USS ARGONNE when that ship was in transport service between the east and west coasts of the U.S. During the summer of 1923, Miss Dauser was one of two Navy Nurses assigned to the USS HENDERSON to care for President Harding on his goodwill tour to Alaska. After their return to the continental U.S., President Harding became ill and Miss Dauser was one of five persons serving at the President's bedside at the time of his death. (One of the doctors in attendance was Captain Joel T. Boone, MC, USN, who was later promoted to VADM.)

Miss Dauser was in charge of the nurses aboard the first U.S. Navy Hospital Ship, USS RELIEF, when in 1925 the United States sent a fleet of ships to Australia and New Zealand on a six-month goodwill tour of the Pacific. From 1926 to 1928, Miss

Dauser had duty in Guam and the Philippine Islands prior to returning as principal chief nurse at the Naval Hospital, San Diego. She subsequently served in charge of nursing activities at Naval Hospitals Puget Sound, Wash., and Mare Island, San Francisco, Calif.; and at the Naval Dispensary, Long Beach, Calif.

In 1939 Miss Dauser was appointed the fifth Superintendent of the Navy Nurse Corps. One of her first acts as Superintendent was the organization of the Naval Reserve Nurse Corps in accordance with the Naval Reserve Act of 6 Oct 1938. Directives were soon in effect and nurse appointments were accomplished in steadily increasing numbers. However, the U.S. Army Nurse Corps was also in the process of building up a reserve nurse corps and their use of relative rank status put the Navy at a disadvantage in its nurse corps procurement endeavor. Consequently new legislation was instituted and on 3 July 1942, Public Law 654 granted relative rank to Navy Nurses. The Superintendent of the Navy Nurse Corps was given the relative rank of Lieutenant Commander. Later on 22 Dec of that same year, Public Law 828 became effective which gave the Superintendent of the Navy Nurse Corps the relative rank of Captain. Miss Dauser was accorded the honor of being the first woman in the U.S. Navy to hold that rank. Further legislation was enacted and on 26 Feb 1944, Public Law 238 granted full military rank to the members of the Navy Nurse Corps. As a result of this law, Sue Dauser was given full commissioned rank of Captain, USN. She retired from active duty on 1 Apr 1946.



On 14 Dec 1945, Captain Dauser (left) was presented the Distinguished Service Medal by James Forrestal, who was then serving as the first Secretary of Defense (right). CAPT Sue Dauser, NC, USN, retired from active duty on 1 Apr 1946. 🇺🇸

INACTIVE NAVAL RESERVE SELECTION FOR PROMOTION

The competition for promotion among inactive Naval Reserve Medical Department officers is keen and is likely to remain that way for some time to come. The Navy is forced to choose individuals best qualified for promotion from among a group of genuinely fine officers. How to determine just who is best qualified is a difficult problem which every Selection Board must face. In making their selections, Board members consider a number of factors which can be grouped into three general categories; Reserve participation, civilian professional training and activities, and fitness reports. Given this information there are several things the reservist can do to enhance the chances of having his record considered in the final selection.

The key word is PARTICIPATION — as actively as possible in the Naval Reserve, and then a little more for good measure. This means drilling regularly, serving on ACDUTRA *every year*, with or without pay and taking correspondence courses. Participation must be consistent over a period of time. While a flurry of activity and a tour of ACDUTRA in the months immediately prior to the convening of a Selection Board demonstrates a certain degree of interest in the Reserve Program, a long history of active participation is much more impressive.

As important as participation is, the small proportion of time spent in drilling does not provide a basis on which to make a final judgement. Civilian activities, of course, represent a greater area for the reservist to exercise professional ability, responsibility and leadership. It is the individual's responsibility to see that his civilian achievements are recorded, if he wants a Selection Board to have an in-depth picture of his capabilities. The way to do this is through the use of the Annual Qualifications Questionnaire (AQQ).

The AQQ should tell the complete story of the officer as a civilian. This is not the place to be modest. All pertinent information concerning civic activities, accomplishments, and updating of professional training, including the professional meetings attended, should be listed. The information should be thorough, but as concise as possible.

The third category considered is that of fitness reports. One serious discrepancy in records frequently seen by inactive Reserve Selection Boards is the absence of reports. In one extreme case a reservist being considered for promotion had not had a fitness report

submitted on him for eight years. This is a serious, but easily avoidable situation. The tear-off receipt form on each report has been designed to assist officers in determining whether all fitness reports due them have been received in BUPERS. The individual owes it to himself to make use of this system of checking on the reporting procedure and to take appropriate action when fitness reports are not submitted.

Finally, it is in the individual's best interest to reply to all official correspondence promptly. It only takes a few minutes to do so. Failure to reply gives the impression that he has lost interest in the Naval Reserve Program. — Code 36, BUMED.

DEFIBRILLATOR WARNING

The Medical Electronics Division of Hewlett-Packard Co. recently distributed a letter to hospital administrators to warn them of a possible hazard in using a Hewlett-Packard or Sanborn Defibrillator.

"WARNING:

Hewlett-Packard or Sanborn Defibrillators (Model Numbers 780-2, 780-2A, 7802A, 7802B, 7802C, 7802D) equipped with Option 001 Synchronizer *may discharge asynchronously when attempting synchronized cardioversion*. During synchronized cardioversion, the defibrillator discharge should occur during the QRS wave of the Cardiac Cycle. However, when using these defibrillators, the discharge may occur at the instant the discharge button is depressed."

This possible hazard is reported absent when the defibrillators are used for non-synchronized defibrillation. At the earliest possible time, there will be a modification that will insure proper synchronized cardioversion. There will be no charge for this modification.

In the meantime, the following steps are recommended:

- 1) Notify all personnel not to use Hewlett-Packard or Sanborn defibrillators in the synchronized mode although they can be used in the *instant mode* for emergency resuscitation.
- 2) Affix Warning Label (which will be provided by your local Hewlett-Packard representative) to the front panel door on a Hewlett-Packard or Sanborn Defibrillator in your hospital.
- 3) Arrange to have your defibrillator modified through the local Hewlett-Packard representative.

OFFICIAL INSTRUCTIONS AND DIRECTIVES

BUMEDINST 3461.1 OF 2 MAY 72

Subj: Medical supplies for Prisoners of War (POW) packages

Reemphasizes the DOD POW Policy Committee recommendation for dispensing medical supplies to certain designated family members for mailing to POW and missing personnel. Provides guidelines and information relative to type and issuance procedures for the medical supplies.

BUMEDNOTE 6220 OF 6 APR 72

Subj: Use of hexachlorophene and procedures for handling staphylococcal disease outbreaks in nurseries

Forwards a copy of USDHEW, PHS ltr which provides information regarding the use of hexachlorophene in hospitals. Also outlines procedures for handling outbreaks of staphylococcal or other skin diseases in nurseries.

BUMEDNOTE 6222 OF 11 MAY 72

Subj: Gonorrhea treatment; revised schedule for

The Center for Disease Control, USPHS, has recently recommended a substantial modification of therapy schedules for gonorrhea. Briefly, significant changes are: (a) Gonococcal urethritis (male or female) should now be treated with 4.8 million units of aqueous procaine penicillin with probenecid instead of the previously recommended smaller doses; (b) Ampicillin is now a preferred drug for the treatment of gonorrhea; (c) Spectinomycin should be reserved for: (1) treatment failure following other antibiotic therapy or reinfection; or (2) cases of allergy to penicillin; and (d) Tetracycline may be used in situations where penicillin or ampicillin is contraindicated.

BUMEDINST 6320.46 OF 12 APR 72

Subj: Patients who require organ transplants

Establishes coordination procedures to be followed in organ transplant cases to insure that the Navy is

responsive to the total needs of family units. There have been circumstances wherein the Navy has been limited in its ability to be of assistance to family members of patients requiring organ transplants who have been evacuated to civilian facilities far removed from major naval facilities. While clinical considerations remain of primary importance, it is essential that the Navy make every effort to provide assistance to family members in such matters as transportation, temporary housing, reassignment when necessary, coordination for follow-up clinical evaluations, and possible coordination with the Navy Relief Society.

Upon determination that a patient will require an organ transplant, and prior to any discussion with the patient or sponsor, the Director, Patient Affairs Division, BUMED, shall be contacted regarding source of care. Medical officers contacting the Bureau should be aware of the overall effects on the patient and his family, and should be prepared to discuss possible sources of care consistent with these requirements. When necessary the Director, Patient Affairs Division, will obtain additional clinical advice and assistance from consultants to the Surgeon General and other appropriate medical personnel.

BUMEDNOTE 6700 OF 11 APR 72

Subj: 70mm X-ray Units

Skin testing has supplanted the 70mm X-ray units as the screening method of choice in the tuberculosis detection and control program. Since there is no alternate Navy Medical Dept. requirement for these units, their use is hereby terminated. Activities will report to BUMED (Code 4A) the make, model, age, and condition code of each 70mm unit in inventory. BUMED will provide further individual disposition instructions.

BUMEDNOTE 6710 OF 10 MAY 72

Subj: Formulary Notes, Vol. I, No. 5

Previously issued DOD regulations regarding the procurement and use of drugs classified by the FDA as "possibly effective" and "probably effective," have been modified. The policy regarding these two categories of drug items has been changed as follows:

(a) Central and local procurement of these items are

authorized when it has been professionally determined that no acceptable substitute is available; (b) Pharmacies and Therapeutic Agents Committees will closely monitor local use of these drugs to insure compliance

with this policy; and (c) The Defense Medical Materiel Board will continually monitor these items and immediately notify all interested agencies as to change in classification by the FDA. ☞

NAVAL DENTAL CORPS CONTINUING EDUCATION PROGRAM

The Continuing Education Courses conducted at the Naval Graduate Dental School, National Naval Medical Center, Bethesda, Md., and the Naval Dental Center, San Diego, Calif., are scheduled during Fiscal Year 1973 as follows:

Naval Graduate Dental School, Bethesda, Md.

<i>Courses</i>	<i>Dates</i>
Oral Diagnosis and Treatment Planning	11-15 September 1972
Occlusion	2-6 October 1972
Operative Dentistry	16-20 October 1972
Oral Surgery	13-17 November 1972
Endodontics	4-8 December 1972
Oral Pathology	8-12 January 1973
Removable Partial Dentures	22-26 January 1973
Preventive Dentistry	5-9 February 1973
Fixed Partial Dentures	5-9 March 1973
Complete Dentures	26-30 March 1973
Periodontics	16-20 April 1973
Restorative Dental Materials	7-11 May 1973
Management Seminar*	21-25 May 1973

*Limited to 20 active duty naval dental officers with the rank of senior commander or junior captain.

Quotas have been assigned to District and Staff dental officers for career dental officers, and Reserve dental officers on active duty, on a space-available basis. District Commandants have likewise been assigned quotas for eligible inactive Naval Reserve Dental officers.

For courses at the Naval Graduate Dental School, applications from career officers and Reserve officers on active duty are to be submitted via the chain of

command and in accordance with current directives, to the Chief, Bureau of Medicine and Surgery (Code 611), Navy Department, Washington, D.C. 20390, using the format shown in MANMED article 6-130. Active status Naval Reserve dental officers on inactive duty will apply to their District Commandant via the Director of Dental Activities or the District Dental Officer, as applicable.

Naval Dental Center, San Diego, California

<i>Courses</i>	<i>Dates</i>
Removable Partial Dentures	11-13 September 1972
Fixed Partial Dentures	2-4 October 1972
Endodontics	16-18 October 1972
Operative Dentistry	13-15 November 1972
Occlusion	4-6 December 1972
Oral Diagnosis	8-10 January 1973
Complete Dentures	29-31 January 1973
Maxillofacial Prosthesis	26-28 February 1973
Oral Surgery	19-21 March 1973
Preventive Dentistry	2-4 April 1973
Periodontics	14-16 May 1973

(Continued on p. 10)

✠ In Memoriam ✠

CAPT Charles A. Castle, MC, USN (Ret.) died 9 May 1972; he was born 18 Aug 1905 in Cincinnati, Ohio. After receiving his B.A. degree from Denison University he attended the University of Cincinnati where he received his M.D. degree and later served as an instructor at the University's College of Medicine. On 1 Oct 1941, Dr. Castle began his naval service at the Naval Hospital Great Lakes, Ill. During WW II CAPT Castle served with the Naval Reconnaissance Party during Operation Overlord and participated in the subsequent campaigns for Cherbourg, Brest, and Le Havre, France. In Jun 1948 he returned to the U.S., was again assigned to the staff at Naval Hospital Great Lakes, and later to the Naval Hospital St. Albans, N.Y. From Sep 1951 to Jul 1954 Dr. Castle served as Head, Tuberculosis Control Section in the Bureau of Medicine and Surgery. His name was placed on the Retired List 1 Sep 1967. CAPT Castle was a Fellow of the Trudeau Society, the American College of Chest Physicians, and the American Medical Association.

CAPT Sue S. Dauser, NC, USN (Ret.) died 8 Mar 1972 in Anaheim, Calif., where she was also born on 20 Sep 1888. She graduated from the California School of Nursing in 1914 and in Sep 1917 was appointed a Naval Reserve Nurse. Her first active duty assignment was in charge of nursing activities with Naval Base Hospital No. 3. In Jul 1918 she was successively appointed Nurse, and Chief Nurse, U.S. Navy. Base Hospital No. 3 was ordered to Edinburgh, Scotland in Aug 1918, replacing a British Naval Hospital Unit. Miss Dauser remained there until after the armistice and returned to the U.S. to assume charge of nursing at the Naval Hospital, San Diego. She later served in USS ARGONNE and USS HENDERSON, and accompanied President Harding on his trip to Alaska. She was one of two nurses caring for President Harding during his last illness and was at his bedside when he died. Miss Dauser was in charge of the nurses aboard the Navy's first Hospital Ship, the USS RELIEF, when that ship participated in a six-month goodwill tour of the Pacific.

In 1939 she was appointed the fifth Supt. of the Navy Nurse Corps. One of her first acts as Supt., was to organize the Naval Reserve Nurse Corps. On 3 Jul 1942 she was given the relative rank of LCDR and later that same year, she acquired the relative rank of CAPT. Miss Dauser was accorded the honor of being

the first woman to hold the rank of captain in the U.S. Navy. Further legislation in 1944 granted full military rank to the Navy Nurse Corps and Miss Dauser was given full commissioned rank as CAPT, USN. She retired from active duty 1 Apr 1946.

RADM Wendell G. Scott, MC, USNR (Ret.) died of cancer on 4 May 1972 in a St. Louis hospital. Dr. Scott was born on 19 Jul 1905, in Boulder, Colo. He received his B.A. degree from the University of Colorado and his M.D. degree from Washington University School of Medicine; in 1936 he was commissioned LT, MC, USNR. From Jan 1942 to May 1943, Dr. Scott served on active duty at the Naval Hospital for Dependents, NAS, North Island, Calif., and at the Naval Hospital San Diego, Calif. He then joined the staff at Naval Hospital Seattle, Wash. as Chief of Radiology and Chief of Rehabilitation Service. For his outstanding service, Dr. Scott received a special citation from the Surgeon General of the U.S. Navy for the development of the Rehabilitation Program at the Naval Hospital Seattle. He was promoted to RADM in Aug 1958 and served as a consultant to the Bureau of Medicine and Surgery. He retired from the Reserve in 1965.

At the time of his death, Dr. Scott was a Professor of Clinical Radiology at the Washington University School of Medicine. He was a prominent figure in the field of oncology and in that connection his name is associated with numerous societies, committees, publications and accomplishments. Since 1964, Dr. Scott had been the Editor of *Cancer*, the monthly scientific journal of the American Cancer Society; during 1963-64 he had been President of the American Cancer Society. Last year he had been appointed by President Nixon to serve on the National Cancer Advisory Board of the U.S. Public Health Service.

LT William R. Strong, MC, USNR (Ret.) died 13 May 1972 at his home in Bethesda, Md.; he was 50 years of age. Born in West Point, N.Y., he attended The Citadel, Charleston, S.C., and received his M.D. degree from George Washington University Medical School, Wash., D.C. While serving on active duty in the Navy, Dr. Strong was a member of the staff at the National Naval Medical Center, Bethesda, Md., where he served as an orthopedic surgeon and later was officer-in-charge of the Tissue Bank there. He was responsible for the design and modification of freeze-

drying equipment used for processing human transplants. After his release from active duty, Dr. Strong continued to serve as a consultant in tissue preservation at the Naval Medical School. His name was placed on the Retired List in Sept 1966.

Dr. Strong was well known in the Wash., D.C. area and he worked closely with the local police and fire departments. He received special recognition for his work as a burn specialist and was instrumental in the creation of the metropolitan area's first Intensive Care Burn Unit which will be dedicated in his honor, at the Washington Hospital Center.

RADM Edward C. White, MC, USN (Ret.) died 24 Mar 1972 in Long Beach, Calif. He was born in River-ton, N.J. on 1 Oct 1883. After graduation from the University of Pennsylvania Medical School, he was commissioned as Asst. Surgeon, LT(jg) on 27 Sept

1905. During his 41 years of naval service, ADM White served at numerous medical facilities including those in the following battleships: VIRGINIA, MISSOURI, MAINE, IDAHO and ARIZONA. From Jan 1917 to May 1918, Dr. White served with the Marine Expeditionary Forces, Santo Domingo. Later, he served as the Medical Officer in Command of the Naval Dispensary, Long Beach and the Naval Hospitals at Pearl Harbor and Boston. In Aug 1940 he was assigned as District Medical Officer, THIRD Naval District. RADM White reported to the Bureau of Medicine and Surgery in March 1942, serving as Inspector of Medical Dept. Activities, Atlantic Coast and later as Inspector for the central area of the U.S. Prior to his retirement in Oct 1946 he served in the Office of the Secretary of the Navy, Wash., D.C. ADM White is survived by three sons and two daughters. ☸

WORKSHOP HELD IN TAIPEI

The Third Pacific Preventive Medicine Workshop, sponsored by the Navy Environmental and Preventive Medicine Unit Number Six, Pearl Harbor, Hawaii, and hosted by Navy Medical Research Unit Number Two, Taipei, Taiwan, was held 10-14 April 1972. The 63 attendees included enlisted and commissioned participants from Chinese, British, and U.S. military medical departments — all involved in the vast technical fields of preventive medicine.

The workshop opened with a keynote address presented by LCDR Gene Jenkins, MSC, USN, on behalf of RADM Charles L. Waite, Commander in Chief Pacific Fleet Surgeon. Admiral Waite's address stressed the importance of environmental and preventive medicine in the world today. He gave high praise to medical, environmental, laboratory, and industrial hygiene officers, preventive medicine technicians, and other participants in the program.

Twelve speakers presented professional papers on a variety of subjects including insect, rodent, and pest control; industrial hygiene; shipboard sanitation; communicable diseases; ecology; and epidemiological intelligence — all of which are of major importance to Pacific ship and shore facilities.

Other topics included new proposals for personnel career planning and a proposal for Navy Medical Department reorganization as related to the many fields of preventive medicine.

The most important parts of the conference proved to be the discussion periods following each presentation. These verbal exchanges resulted in new ideas which could result in an even higher level of professional excellence, improved health standards, and increased efficiency through better personnel motivation and utilization. ☸

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ILLEGAL FASHION

A recent fad — the informal wearing of articles of military uniform — indicates that many are ignorant of the following Federal law:

"Whoever, in any place within the jurisdiction of the United States or in the Canal Zone, without authority, wears the uniform or a distinctive part thereof or anything similar to a distinctive part of the uniform of any of the Armed Forces of the United States, Public Health Service or any auxiliary of such, shall be fined not more than \$250 or imprisoned not more than six months, or both."

Many installations throughout the United States will soon begin enforcing the law prohibiting the unauthorized wear of uniforms and parts of uniforms, so keep in mind that you MAY NOT wear, with civilian clothes, the class A uniform blouse; insignia to include shoulder patches, unit crests, rank, "U.S." and branch distinctions; service or overseas caps; and field jackets with patches, labels and rank still affixed. You MAY wear stripped field jackets, fatigues and khakis.—AFPS, Washington, D.C.



United States Navy Medicine

CORRESPONDENCE AND CONTRIBUTIONS from the field are welcomed and will be published as space permits, subject to editing and possible abridgment. All material should be submitted to the Editor, U.S. Navy Medicine, Code 18, Bureau of Medicine and Surgery, Washington, D.C. 20390

NOTICES should be received not later than the third day of the month preceding the month of publication.

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SUGGESTIONS are invited concerning U.S. Navy Medicine, its content and form.

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Seated in the Navy A-7 Corsair II attack jet named in honor of her father is Desti Dee Thornton (left), ten-year-old daughter of POW LT Gary L. Thornton. Desti was the guest of her CACO (Casualty Assistance Calls Officer), LCDR James E. Bosley, DC, USN (right), Preventive Dentistry Officer at the NAS Lemoore Dental Dept. LCDR Bosley made arrangements with the Executive Officer of VA-125 to have LT Thornton's name placed on a squadron jet. As a part of their awareness and remembrance program for American prisoners of war and men missing in action, VA-125 has named each aircraft in their squadron for a POW/MIA.—Photo by PH2 T.N. Ludden, NAS, Lemoore, Calif.